SCOTTISH HOSPITALS INQUIRY

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

Bundle 37 – Board Minutes and Relevant Papers

SCOTTISH HOSPITALS INQUIRY

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GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Thursday 27 June 2002 at 3.00 pm**

P R E S E N T

Professor G C A Dickson (in the Chair)

Mr J Best	Mr W Goudie
Ms M Boyle	Councillor J Gray
Dr H Burns	Councillor J Handibode
Mr R Calderwood	Dr R Hughes
Mr R Cleland	Mrs S Kuenssberg CBE
Councillor D Collins	Dr F Marshall
Mr T Davison	Councillor D McCafferty
Mr T A Divers OBE	Mr A O Robertson OBE
Councillor R Duncan	Mrs E Smith

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

Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms C Renfrew	Director of Planning and Community Care

B Y I N V I T A T I O N

Ms C McCalman	Vice-Convener, Greater Glasgow Health Council
Ms L Love	Representative, Area Nursing and Midwifery Committee
Dr J Nugent	Chair, LHCC Professional Committee

ACTION BY

72. APOLOGIES

Apologies for absence were intimated on behalf of Professor M Farthing (Executive Dean, Faculty of Medicine, University of Glasgow), Professor D L Hamblen (Chairman), Mrs W Hull (Director of Finance), Mrs C Anderson (Chair, Area Pharmaceutical Committee), Dr F Angell (Chair, Area Dental Committee), Mrs E Borland (Acting Director of Health Promotion), Mr P Hamilton (Convener, Greater Glasgow Health Council), Mr E P McVey (Chair, Area Optometric Committee), Ms S Plummer (Nurse Adviser).

ACTION BY

73. ACCIDENT, EMERGENCY AND ORTHOPAEDIC SERVICES

A report of the Chief Executive, Director of Planning and Community Care and Director of Public Health [Board Paper No. 02/48] was submitted asking the Board to consider further detailed work on the shape of Accident, Emergency and Orthopaedic Services. On the basis of that further work, the Board was asked to confirm the proposed shape of Accident, Emergency and Orthopaedic Services for submission to the Scottish Executive. This was outlined as follows:-

- Full Accident and Emergency (A&E) services would be provided on two sites, one north and one south.

- Minor Injuries Units would be provided on five sites at Gartnavel, Stobhill, Victoria, Glasgow Royal Infirmary and the Southern General.

- Acute receiving services would be provided on the three in-patient sites.

- Trauma and orthopaedic in-patient services would be provided on two sites – one north and one south, but retaining locally accessible out-patient and day case services.

Professor Dickson underlined the importance of the paper on Accident & Emergency and Orthopaedic Services, this being the final element of the Acute Services Strategy and the Board's recommendations would be submitted to the Minister for Health and Community Care to allow consideration to be given to the totality of the Strategy.

The key issues to be considered went beyond that of blue light emergency referrals - it included minor injuries, medical receiving, GP emergency referrals and Accident & Emergency for children and much of this would form the debate.

It was recognised that the overall strategy delivering this shape of services would take ten years to implement.

Professor Dickson suggested that the debate be structured with Mr Divers leading with an overview of the proposals and principles, followed by questions from Members and thereafter general discussion and debate – this format was agreed.

Mr Divers reminded the Board that in concluding its deliberations at the January 2002 meeting, it re-stated its working hypothesis that accident and emergency and trauma services should be provided from two, fully resourced A&E centres in north and south Glasgow working with a GP emergency receiving unit in west Glasgow. At that time, it was recognised, however, that further work should be undertaken on the following:-

- The model of acute receiving at Gartnavel General Hospital.

- Patient flows and numbers.

- Designing services at Glasgow Royal Infirmary to deal with large volumes of patients.

ACTION BY

This further work had been undertaken to enable the Board to reach a final decision and it would also enable the Minister for Health and Community Care to consider and take decisions on the totality of the Board's Acute Services Strategy.

He described the term accident and emergency services which had traditionally covered a range of very different needs from patients with the most minor injuries and illnesses to those who were very seriously ill or injured. The essence of the proposals was to provide the appropriate level of services to meet the needs of different patient groups – moving away from the concept of an overloaded accident and emergency department providing the only immediate access to hospital services.

Mr Divers described the proposed shape of services and patient volumes and highlighted, in particular, the following:-

- For adult accident and emergency services – there would be two major units – one at the Southern General and one at Glasgow Royal Infirmary. Based on trends, it was expected that the total number of A&E attendees would remain relatively stable but the number of emergency admissions were rising. In geographic terms, he expected the service at Glasgow Royal Infirmary to serve the north and east of Glasgow as well as the Rutherglen/Cambuslang area. The Southern General would provide a service for patients in the south and west of Glasgow.

- For children's accident and emergency – the new arrangements meant that all children under the age of 13 years requiring A&E services would be seen at an enlarged facility at Yorkhill. This would ensure that all patients had access to dedicated paediatric facilities and staff and would ensure uniformity of management of paediatric emergencies.

- For orthopaedics – trauma and Orthopaedic inpatient services would be provided from two sites - one North and one South. Local provision would be through an out-patient and day case service at the Victoria and Stobhill Ambulatory Care Hospitals, Glasgow Royal Infirmary, Gartnavel and Southern General sites, each serving the populations of the current catchment areas. Based on trends, it was expected that trauma workload would remain static or decline and elective and out-patient activity would increase, marginally.

- Minor Injuries Units (MIU) – there would be five Minor Injuries Units, at the Victoria, Southern General, Gartnavel, Glasgow Royal Infirmary and Stobhill. These would be staffed by Nurse Practitioners probably open twelve hours per day and would provide locally accessible services to patients who referred themselves. Each MIU would be linked to a parent A&E department for training and clinical supervision. It was estimated, based on an analysis of Glasgow's data, that between 25% and 30% of current accident and emergency cases would access these facilities.

- Dealing with GP referrals – it was proposed that each of the three in-patient sites would have services designed to provide immediate access to specialist assessment and admission for GP referral. The Gartnavel service would deal with GP referrals for west Glasgow, the Glasgow Royal Infirmary for those from north, east Glasgow and Rutherglen/ Cambuslang and the Southern for referrals from the rest of south Glasgow.

Mr Divers drew particular attention to two responses to the Board's proposals: one from the Area Medical Committee and the other from Greater Glasgow Health Council.

The Area Medical Committee submission set out the conditions it felt must be met for a two-site option for A&E and Orthopaedic services. Mr Divers described the conditions and was confident that the Area Medical Committee's caveats would be addressed as progress was made to implement the proposals.

In following up a point made earlier by Mr Robertson, Professor Dickson asked Dr Hughes, Chairman of the Area Medical Committee (AMC) if the second paper on the agenda on the review of the management of acute admissions addressed the issues raised by the AMC in its consideration of Accident & Emergency and Orthopaedic Services. Dr Hughes replied that the review was welcomed and did address the issues that had concerned the AMC.

Greater Glasgow Health Council was of the view that the NHS in Greater Glasgow would be best served by having the options and flexibility which three accident and emergency units would provide. They recognised that in five or ten years time, the pressures on hospitals would be such that a shift to the two centre option might be feasible and acceptable at that time.

Mr Divers summed up by describing that the working hypothesis of:-

- two full A&E services at Southern General Hospital and Glasgow Royal Infirmary;
- five Minor Injuries Units;
- two orthopaedic and trauma services;
- a GP-referred acute admissions service at Gartnavel

was a viable solution to achieve its primary objectives as follows:-

- a gold standard orthopaedic and A&E service with strong Consultant presence;
- local access for minor injuries and GP referrals;
- the most efficient service delivery.

Dr Burns referred to the work undertaken by the A&E Planning Group and, in particular, to its extensive data collection exercise which had formed an important element of its work. Data analysis illustrated streaming of patients currently defined as accident and emergency activity in the following ways:-

ACTION BY

- acute receiving – a receiving point for medical and surgical emergency referrals from GPs, some of which would require resuscitation and emergency stabilisation;

- accident and emergency – patients with multiple injuries requiring a prompt trauma response;

- minor injuries – a minor injuries service which could be provided by Nurse Practitioners working to clinical protocols determined by A&E Consultants.

Dr Hughes referred to a typographical error on page five of the Board papers where it referred to 100 orthopaedic day cases at Stobhill. Ms Renfrew confirmed that this should, in fact, read 1,000 orthopaedic day cases at Stobhill.

In response to a question from Councillor Handibode, Mr Divers clarified that the catchment areas for the five Minor Injury Units and two ACADS would be the current catchment areas thus ensuring a consistent pattern of local access was maintained.

Councillor Duncan reiterated the tension and concern over local access and public transport links and encouraged the Board to ensure that the residents of Greater Glasgow had a better standard of public transport links to these proposed new services.

Councillor McCafferty referred to page seven of the Board paper and, in particular, the advice from the Area Medical Committee which stated that : "*A wide range of medical opinion had been sought on these proposals and some of this opinion had been supportive of the Board's proposals whilst other opinion had not been supportive.*" Councillor McCafferty had reservations about the Board's ability to address such complex issues particularly when opinion was so split – not only from a clinician viewpoint but also that from members of local communities.

Mr Goudie referred to the fact that, to date, the Health Council had not received the results of the Bed Modelling Steering Group and that this had left many of its members with concerns about Glasgow Royal Infirmary's ability to cope, in the future, with the increased pressures it would face, particularly if the A&E department was closed in west Glasgow. Mr Divers confirmed that the Board awaited the publication of the next set of annual figures and that, at that time, this would be shared with Greater Glasgow Health Council. An annual review on bed modelling would be submitted to the NHS Board for consideration.

Mr Calderwood confirmed that the bed modelling figures for 2001/2002 would be available in September 2002 but that the bed requirement for Greater Glasgow had been "frozen" at 2,880 beds in the last calendar year – 2000. Following the release of the 2001/2002 bed figures, the physical positioning of these beds on the three in-patient sites would be further debated.

In response to a question from Dr Nugent, Mr Divers commented that there was recognition of the service currently being delivered by Glasgow Emergency Medical Service (GEMS) and how this would impact on the Board's proposals. This interface was key and would form part of the work being developed particularly in relation to the Minor Injuries Units.

ACTION BY

Dr Hughes, on behalf of the Area Medical Committee, strongly urged the Board to come to a decision as the status quo was no longer tenable and any further delay would not be in the best interests of patients or staff.

Mr Davison referred to the conflicting views already referred to and concluded that although a number of options could work, the complexity of various components within Greater Glasgow meant that it needed and could sustain the model of three acute medical receiving units and two trauma units – he concluded that this was the best fit decision.

Councillor McCafferty welcomed much of the paper but expressed concern that local communities wanted to see a full A & E Department at Gartnavel. He sought a compromise and was anxious that the Board did not make an irreversible decision particularly when opinion was split and there appeared to be doubts from clinicians on the Board's proposals. His preference would be to start with three A&E units with a view to possibly reducing this to two units following a review. He was concerned that the two A&E centres would be overloaded and referred, in particular, to the poor public access and transport infrastructure that currently existed. He regarded this as being outwith the control of the Board and referred, in particular, to the population of Clydebank who would attend the Southern General Hospital site via the Clyde Tunnel if the Board's proposals were approved.

His interpretation of the Area Medical Committee's response compounded this particularly in its caution, reluctance and seven conditions. Councillor McCafferty was of the view that the Board could not promise that these issues would be rectified prior to implementation. It was his understanding that Greater Glasgow Health Council, the A&E Subcommittee, the Orthopaedic profession and West Dunbartonshire Council all would prefer three A&E sites and the Board had to be seen to be open, transparent and listening to the views of the Communities and these key stakeholders.

Dr Burns referred to the two site option and its 24-hour service providing CT scanning, ultrasound and resuscitation for major accidents, head injuries, skull injuries and chest pains and commented that if this was diluted to three sites the level of expertise could not be kept at its peak. He referred to evidence that suggested following clear educational information, local patients did present at the right centre, either trauma or Minor Injuries Unit that best met their needs at that time. Given the rapidly changing technology, he was keen that the Board move to 21st Century working and it was not the case any longer that the only way a patient could get to a hospital was via an A&E door – many doors were now available to patients and this should be the way Greater Glasgow streamlined its services.

Dr Marshall reiterated the view that the proposals were for NHS Greater Glasgow and that a dispassionate objective view should be taken in relation to the needs of various parts of the city and how health care would be best provided in ten years time. Access was not merely geography – it was a case of getting patients to the right place at the right time and providing better and safer services in Glasgow.

Dr Nugent commented that it was to the benefit of patients to provide two gold star A&E centres which were well equipped and it should be emphasised that to go to one of the two centres would mean patients were seeing specialists in their field, particularly as the concentration of fewer sites meant that this could be provided.

ACTION BY

Mr Robertson referred to the timescale to make this decision and the importance to Greater Glasgow patients to provide a credible and realistic service – it was his view that two A&E services would do this.

Mr Goudie referred to the vast amount of patients who would continue to receive care and treatment at the three medical receiving units and two Minor Injury Units as well as the two proposed A & E units. He described the benefits to patient care which the proposals offered in that patients could have confidence that they were being treated in the right environment by a specialist in the field whether it be at one of the A & Es, MIUs or Medical Receiving Units.

DECIDED:

- That the report of further detailed work on the shape of Accident, Emergency and Orthopaedic Services be considered. **Chief Executive**

- On the basis of that further work, the proposed shape of Accident, Emergency and Orthopaedic Services for submission to the Scottish Executive as follows be confirmed:- **Chief Executive**

    - full Accident and Emergency services be provided on two sites, one north (Glasgow Royal Infirmary) and one south (Southern General);

    - Minor Injuries Units be provided on five sites at Gartnavel, Stobhill, Victoria, Glasgow Royal Infirmary and the Southern General;

    - Acute receiving services be provided on the three in-patient sites, Royal Infirmary, Southern General and Gartnavel General Hospital;

    - Trauma and Orthopaedic in-patient services be provided on the two sites – which house full A & E Services, but retaining locally accessible out-patient and day case services on all five adult acute sites.

    - Paediatric Accident and Emergency Services should be centralised at the Royal Hospital for Sick Children, Yorkhill.

  Councillor McCafferty requested that his dissent be recorded against the decision not to have a full A & E Department at Gartnavel General Hospital. He supported all other proposals within the paper.

74. REVIEWING THE MANAGEMENT OF ACUTE ADMISSIONS

A report of the Director of Planning and Community Care and Director of Public Health [Board Paper No. 02/49] was submitted asking the Board to endorse the proposed review of acute admissions.

It was proposed to undertake a rapid review of acute receiving services across Greater Glasgow for approval and implementation in support of the implementation of decisions on the future shape of emergency care in Greater Glasgow.

ACTION BY

The review was in response to a number of factors and, in particular, widespread evidence that the current emergency care arrangements were operating under severe strain. It was the expectation that the outcome of the review would include:-

- proposals for change to:
  - clinical infrastructure including imaging, pharmacy etc.;
  - system changes – for example, to receiving arrangements;
  - investment to resolve capacity and organisational uses.
- These changes to deliver significant reduction to:
  - waiting times for admission in A&E;
  - patients boarded outside their specialty of admission.
- Building on the outline of the clinical strategy for accident and emergency services a clear plan:-
  - for migration to the final shape of services over the next eight to ten years;
  - based on a realistic appraisal of likely demand, the resources required to deliver the service required on each site.

DECIDED:

That the proposed review of acute admissions be endorsed. **Chief Executive**

Meeting ended at 4.20 pm

GGNHSB(M)02/09
Minutes: 83 - 96

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 20 August 2002 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr J Best	Professor M Farthing
Dr H Burns	Councillor J Gray
Ms M Boyle	Mr W Goudie
Mr R Calderwood	Dr R Hughes
Councillor D Collins	Mrs W Hull
Ms R Crocket	Mrs S Kuenssberg CBE
Mr T A Divers OBE	Mrs E Smith

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

Ms E Borland	Acting Director of Health Promotion
Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Dr H Irvine	Consultant in Public Health Medicine (for Item 88)
Mr J Whyteside	Communications Manager

B Y I N V I T A T I O N

Dr F Angell	Chair, Area Dental Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Mr H Smith	Chair, Area Paramedical Committee (PAMS)

ACTION BY

83. APOLOGIES

Apologies for absence were intimated on behalf of Mr R Cleland (Chairman, North Glasgow University Hospitals NHS Trust), Mr T Davison (Chief Executive, Greater Glasgow Primary Care NHS Trust), Professor G C A Dickson (Interim Chairman), Councillor R Duncan, Councillor D McCafferty, Ms C Renfrew (Director of Planning and Community Care), Ms S Plummer (Nurse Adviser to the Board), Mrs C Anderson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mr E P McVey (Chair, Area Optometric Committee) and Dr J Nugent (Chair, LHCC Professional Committee).

ACTION BY

84. APPOINTMENT OF CHAIR

In the absence of a Chair and the Interim Chair, on the motion of Mrs E Smith, seconded by Professor M Farthing, it was agreed that Mr A O Robertson chair the meeting.

85. CHAIRMAN'S REPORT

The Chairman made reference to events in which the Interim Chair, Professor G C A Dickson, had been involved since the last meeting of Greater Glasgow NHS Board. These included the following:

(a) Attendance on 29 July 2002 at a visit to Glasgow by the Deputy Minister for Health and Community Care, Mr Frank McAveety. He visited the Southern General Hospital, Glasgow Royal Infirmary and the headquarters of the Glasgow Homeless Addictions Team which gave the opportunity for discussion on the Joint Homelessness Strategy.

(b) Chaired the Appointments Committee on 13 August 2002 to appoint a Director of Corporate Communications for NHS Greater Glasgow. Alastair McLaws, currently Head of Communications at NHS Lanarkshire, had been appointed to the post and was expected to start in October 2002

(c) Attendance on 16 August 2002 at an NHS Board Chairs' meeting with the Minister for Health and Community Care and Chief Executive of NHS Scotland. Discussion at the meeting concentrated on:

- The implementation of the current Health Plan.
- The development of the Health Policy White Paper - expected to be issued during the winter of 2002.
- A review of the Guidance for Local Health Plans.

Mr Robertson advised that he had attended a visit by Mr Frank McAveety, Deputy Minister for Health and Community Care at West Dunbartonshire Council Offices. The Assistant Director for Planning and Community Care, Mr Alex McKenzie, presented the ongoing work being undertaken between NHS Greater Glasgow and West Dunbartonshire Council in taking forward the Joint Future agenda.

Mr Robertson confirmed that the Acting Director of Health Promotion, Evelyn Borland, had written out to all Board Members advising of the arrangements of the first City Health Week, taking place between 8 and 15 September 2002. This event was being organised primarily by Glasgow City Council, with support from the Health Promotion Directorate at Greater Glasgow NHS Board and the theme of the week would be "Glasgow's Busy Beeing Healthy" - using the character of a bee in publicity materials. The Health Week was an opportunity to increase understanding among the public and partners of the importance of health to Glasgow's image and welfare and to underline the commitment that already existed to tackle Glasgow's health problems.

NOTED

ACTION BY

86. MINUTES

On the motion of Mrs E Smith, seconded by Councillor D Collins, the Minutes of the meeting of the NHS Board held on Tuesday 23 July 2002 [GGNHSB(M)02/08] were approved as an accurate record and signed by the Chairman.

NOTED

87. ACCOUNTABILITY REVIEW 2001/2002 - OUTCOME

A report of the Chief Executive was submitted [Board Paper No 02/52] asking the Board to receive the record of the outcome of the annual accountability review meeting between NHS Greater Glasgow and the Scottish Executive and to note progress made on the set of early action points arising from that review.

The annual accountability review meeting between NHS Greater Glasgow and the Scottish Executive was held on 20 June 2002 at Dalian House. It was attended by the five NHS Greater Glasgow Chairs and Chief Executives, Bill Goudie (Chair, Area Partnership Forum), the Chief Executive of NHS Scotland, Trevor Jones and his team. A record of the outcome of the meeting was set out in a letter from Trevor Jones on 10 July 2002 to Professor David Hamblen, then Chairman of the NHS Board. Mr Divers referred to the copy of that letter which was included in the Board papers and which would be included in its annual report 2001/2002 and a summary of the action to be taken by NHS Greater Glasgow.

Mr Divers commented that the meeting had been positive, constructive and with plenty of opportunities for both parties to raise issues. He provided a brief update on the points identified as early action points arising from the accountability review meeting as follows:

- Area Partnership Forum - a meeting of the Area Partnership Forum had taken place in the week following the accountability review meeting. A draft work programme for the present year was discussed and should be finalised at the September meeting of the Area Partnership Forum. Additionally, the Joint Chairs of the Forum had had an initial meeting with UNISON and ongoing discussion would take place in the coming weeks.

- Major Service issues - a final submission on the Acute Services Strategy was made to the Chief Executive of NHS Scotland and to the Minister for Health and Community Care immediately following the NHS Board meeting held on 27 June 2002. The Minister for Health and Community Care had now completed his detailed consideration and scrutiny of all three submissions which the NHS Board had submitted. On 10 August 2002 the Minister wrote to the Interim Chairman, Professor Gordon Dickson, and gave approval to the proposals flowing from Greater Glasgow's acute services strategy. The details of the ministerial decision were as follows:

  - ❖ That the clinical strategy based on three adult inpatient sites, supported by two Ambulatory Care and Diagnostic Units (ACADs) on the Stobhill site and on a site adjacent to the Victoria Infirmary site was the appropriate pattern for future years.

  - ❖ In North Glasgow, acute inpatient services would be provided from the redeveloped Glasgow Royal Infirmary and Gartnavel General Hospital.

ACTION BY

- ❖ In South Glasgow, acute inpatient services would be provided from a major new development at the Southern General Hospital.

- ❖ That full A & E services would be provided from two sites located at Glasgow Royal Infirmary and the Southern General Hospital and that:

  - ➢ Acute receiving services would be provided from three inpatient sites at Glasgow Royal Infirmary, Gartnavel and Southern General Hospital.

  - ➢ Trauma and Orthopaedic inpatient services would be provided from the two full A & E sites. Orthopaedic outpatient and day case services to be provided from all five adult sites.

  - ➢ Minor Injuries Units would be provided from all five adult sites (Gartnavel, Stobhill, GRI, Victoria and Southern General).

  - ➢ Paediatric A & E and Emergency Services would be provided from the Royal Hospital for Sick Children at Yorkhill.

In his letter of approval, the Minister also welcomed the NHS Board's proposal that Audit Scotland undertake a governance role in respect of implementation of the acute services plan. The Minister had asked that the final remit agreed between the NHS Board and Audit Scotland be shared with his Department as soon as that had been finalised.

- Financial Issues - the two immediate action points arising from the discussion on financial issues had been taken. Mr Divers and Ms Hull met with the Health Department's Director of Finance and members of his team on 2 August 2002 to take forward the next steps in the discussion about the development of the five year financial plan. An agreed timescale for an initial submission (by end August 2002) and of a more detailed submission (by end December 2002) had been agreed. Furthermore, NHS Greater Glasgow's five Directors of Finance had met on 19 August to move this forward.

- Waiting Times - a detailed report had been sent to the Director of the National Waiting Times Unit setting out the proposals for the next year and a half, in order to address the key ministerial waiting time targets.

In summary, Mr Divers highlighted the priorities for NHS Greater Glasgow for the year 2002/2003 being:

- To manage within available resources.

- To manage the capital programme to sustain implementation of the acute services review.

- To deliver the targets for waiting times.

- To maintain progress to develop the Beatson Oncology Centre.

- To make progress on the eradication of instances of hospital acquired infection.

- To develop the staff governance agenda.

ACTION BY

Mr P Hamilton was concerned to note the lack of reference to consultation and public involvement which were regarded as imperatives to the delivery of NHS services. Mr Divers advised that not every key priority featured in the review and that there should be no doubt of the importance NHS Greater Glasgow and the Scottish Executive attached to consultation and public involvement. Whilst it may have been reassuring to see this written in the accountability review, there was no lack of commitment from either the Scottish Executive or Greater Glasgow NHS Board to taking this forward. Mr Hamilton suggested that it could perhaps be argued that a patient representative attend future accountability review meetings. Mr Divers commented that the accountability review meeting had taken on a different format this year with the attendance of the Chair of the Area Partnership Forum and it may be that engagement with such agencies as Health Councils may take place in the future. It was agreed that Mr Divers would submit these comments to the Chief Executive of NHS Scotland to highlight the sense of feeling. Greater Glasgow Health Council would also write to the Chief Executive of NHS Scotland on the issue they had raised. **Chief Executive**

DECIDED:

- That the record of the outcome of the annual accountability review meeting between NHS Greater Glasgow and the Scottish Executive be received. **Chief Executive**

- That the progress made on the set of early action points arising from that review be noted and that a quarterly report on progress be submitted to the NHS Board. **Chief Executive**

88. PUBLIC HEALTH ISSUE : CRYPTOSPORIDIUM

Dr Burns welcomed Dr Helene Irvine, Consultant in Public Health Medicine who had chaired the cryptosporidium outbreak control team in 2000. Dr Jim McMenamin had chaired the cryptosporidium outbreak control team 2002 but due to other commitments was unable to attend the Board meeting.

Dr Burns presented the key information in relation to the recent cryptosporidium outbreak - comparing this with the May 2000 outbreak. He described the nature of cryptosporidium as a ubiquitous protozoal infection with several sub types. These were fairly species specific and not all were infective in humans. Generally, cryptosporidium arose from contact with faeces.

He described the way that water was collected in Scotland in that for as long as water was collected on the surface, there was a risk that it could be contaminated by cryptosporidium. He described the complex water network supply from Loch Katrine and the associated two aqueducts. He referred to data which indicated that there was a peak of cryptosporidium at spring time and this could be linked with the lambing season particularly around the surrounding farmland at Loch Katrine. He highlighted that the laboratory confirmed cases reported to Scottish Centre for Infection and Environmental Health were less within the Greater Glasgow NHS Board area than was the case Scotland wide. He compared the May 2000 and current incident outbreaks as follows:

May 2000 Outbreak	Current Outbreak
• 90 cases	• heavy rains
• many in North Glasgow	• increased turbidity
• high rainfall causing increased turbidity of water	• rising level of cryptosporidium at Mugdock

ACTION BY

- no routine monitoring of cryptosporidium
- disagreement on cause of outbreak
- West of Scotland water did not endorse the report of the outbreak control team
- it was accepted that the most likely source of the outbreak was water borne but there was no conclusive evidence which linked the human cases to sheep faeces in the catchment area of Loch Katrine
- no forensically solid chain of evidence linking Loch Katrine to cases
- in the view of the Consultants in Public Health Medicine and the Environmental Health Officers, a very high probability of a link existed
- public health protection required action on sheep around Loch and repair of aqueducts
- health anxieties about continued presence of sheep in area
- notify the public about risk after the sheep were removed. Assess new risk before anything could be communicated
- At risk groups - GPs notified of extended list of diagnoses
- decision to inform public about spring time risk of sheep on the hill
- West of Scotland Water decision to remove sheep
- risk radically reduced
- monitoring programme started
- rising levels in aqueduct
- problem assessment group
- incident management team
- boil water notice
- action taken at less than 0.4 cysts per 10 litres
- agreed action to reduce exposure
- agreed levels for rescinding notice
- monitoring continues

Dr Burns paid tribute to the Scottish Water engineers involved in the handling of the 2002 cryptosporidium outbreak. Similarly, Mr Robertson commended the work undertaken by the Consultants in Public Health Medicine at the NHS Board who had handled the situation in a speedy and professional manner. As yet no person had contracted cryptosporidial diarrhoea from this incident and the ongoing process had been revealing with many lessons learned as the situation developed.

In response to a question from Dr Frank Angell, Dr Burns confirmed that he was not aware of any filter available that could be used in dental practice for the cooling jets which removed cryptosporidium from the water supply. He expected that some general dental practitioners may have used bottled water.

In response to a question from Professor Farthing, Dr Irvine advised that prior to the decision being made to advise people to boil water, the detection rate for cryptosporidium had gone up significantly. She further clarified that the analysis of a sample was taken from 1,000 litres of filtered water over 24 hours.

ACTION BY

Mr Goudie referred to local controversy regarding the ability of the plant proposed for Mugdock reservoir. Dr Burns confirmed that NHS Greater Glasgow would take advice from experts in this field but that if a treatment works was in place then the risk of such outbreaks would be greatly reduced.

In response to a question from Dr Hughes, Dr Burns advised that he was not yet able to confirm whether the cryptosporidium was pathogenic - this was currently being tested.

The Incident Team report into the recent outbreak would be submitted to the NHS Board when available. **Director of Public Health**

NOTED

89. CONSULTATION AND PUBLIC INVOLVEMENT IN SERVICE CHANGE : DRAFT INTERIM GUIDANCE

A report of the Chief Executive [Board Paper No 02/53] was submitted asking Members to note the Consultation and Public Involvement in Service Change : Draft Interim Guidance which replaced the Scottish Home and Health Department 1975 Circular entitled "Closure and Change of Use of Health Service Premises".

Greater Glasgow NHS Board had been asked to offer comments on the draft Interim Guidance and Mr Divers set out a proposed response which had been informed by a dialogue with Greater Glasgow Health Council.

The renewed emphasis in the draft Guidance on patient, public and community involvement was welcomed. The Board had a programme of work in place to develop its local approach to public involvement and to deliver on the commitments made in the December 2001 Scottish Executive Health Department Guidance "Patient Focus and Public Involvement", which followed up commitments made in the Scottish Health Plan.

While welcoming the Guidance and its emphasis in general terms, Mr Divers led the Board through a number of specific points to be made in the Board's response including:

- The absence of any stratification in the form of consultation appropriate for different service changes.

- Stratification of interests - the Board's general approach would be to place service users and carers at the centre of involvement and consultation.

- Primary Care - the potential role of LHCCs in public consultation and involvement and how this could be encouraged particularly with primary care practitioners.

- Local Authorities - recognising the increasing work done in tandem with Local Authorities, thought needed to be given to developing guidance to public bodies, in general, rather than simply focussing on the NHS.

- National Policy - recognising that the Board would often be required, to varying timescales, to implement national policy which may severely restrict the ability for local consultation to influence outcomes or, when centrally set timescales were short to even enable a meaningful local process.

ACTION BY

The national guidance needed to be realistic in its scope and avoid generating public expectations on the breadth and depth of consultation which could not be met and simply run the risk of discrediting NHS consultation processes.

Councillor Collins welcomed the document and saw this as a step forward in public involvement. One crucial point, particularly in working with Local Authorities, was timing and he suggested that a plan should be drawn up giving cognisance of ensuring adequate opportunities to Local Authorities to discuss plans at the earliest stages - such a mechanism would need to be developed. Mr Divers recognised this challenge and hoped to ensure adequate opportunity for joint debate.

Mr P Hamilton referred to the helpful meeting with Mr Divers, Ms Renfrew and Greater Glasgow Health Council and confirmed that Greater Glasgow Health Council intended to respond to the consultation exercise and had views not dissimilar from that of the NHS Board.

Councillor Gray saw the benefit in publicising the Board's intention (in leaflet form) in relation to public involvement and consultation to ensure it reached a broad audience. He saw this as a good start particularly in striving to improve messages given to the residents of Greater Glasgow.

Ms Crocket drew attention to the document's lack of clarity in relation to "significant change" - it would have to be clear what was meant by *significant*. She recognised that consultation was not an end process but must happen at the very beginning to shape services in the future - it was very much an educating process. Given this, it should be borne in mind that the process may be time consuming and this should be reflected in the Board's response.

Mrs Kuenssberg referred to paragraph 19 of the draft interim guidance and was mindful that an acknowledgement should be made to the possible wide range of conflicting views that would be received when consultation exercises took place. Ultimately, it was the decision makers who had to balance these responses before coming to a decision and as such it was important to know the parameters of the consultation. Dr Hughes re-iterated this point acknowledging that the onus to make decisions based on the outcomes of consultations lay with decision makers.

DECIDED:

That the Chief Executive draw together all the comments received on the Consultation and Public Involvement in Service Change : Draft Interim Guidance and submit a response to the Scottish Executive. **Chief Executive**

90. FINANCIAL MONITORING 2001/02

A report of the Director of Finance [Board Paper No 02/54] asked Members to note the final outturn for Trusts for the year to March 2002, based on Audited Annual Accounts and the cumulative Income and Expenditure Surplus position for Trusts and the NHS Board.

ACTION BY

Mrs Hull described for each Trust and in total, the final financial outturn for the year to March 2002. The information was an extract from Trusts' Audited Annual Accounts and, in total, the Trusts achieved a surplus of £972K against the break even (operational) target. After accounting for profits/(loss) on sale of land and buildings, the final outturn was £1094K in surplus. This compared with the previous forecast outturn of £1041K. Given the level of funding available to NHS Greater Glasgow, this represented a remarkably good outcome to a difficult financial year. In achieving this result, the NHS Board acknowledged the open and constructive co-operation that had been a feature of working with the Trusts during the year.

Mrs Hull referred to the cumulative income and expenditure to March 2002 for the Trusts and the Board. Having received £13.6M from the Scottish Executive Health Department during 2001/02 to fund the accumulated deficits at the North and South Glasgow Trusts, the Trusts were now £7.8M in surplus. The Board showed an accumulated £10.1M deficit. The opening cumulative deficit for the Board of £10.7M included the provision of £6.7M for legal claims (mainly medical negligence). As this related to claims for incidents which took place before Trusts were established, the balance should reduce over time when the claims settled.

DECIDED:

- That the final outturn for Trusts for the year to March 2002, based on audited annual accounts be noted.

- That the cumulative income and expenditure surplus position for Trusts and the Board be noted.

91. CAPITAL PLANNING 2002/03 UPDATE

A report of the Director of Finance [Board Paper No 02/55] was submitted asking the Board to approve the further release of £15.2M capital funds in 2002/03. Furthermore, the Board was asked to note the retention of the remaining £8M for release following further consideration of the acute strategy requirements and related priorities in 2002/03 contingent on the process for agreeing a 3/5 year capital plan.

At its June 2002 meeting, the NHS Board received a report setting out details of the revised capital planning process and the funding available to the NHS Greater Glasgow in 2002/03 and beyond. At that time, the Board agreed to:

- confirm the allocation of an initial tranche of £16M capital funds to Trusts;

- consider the further distribution of remaining capital funds at a later meeting.

Mrs Hull provided an update on the process to develop a capital plan for 2002/03 and beyond. She described the two steps in finalising proposals to allocate remaining capital funds. Stage one involved obtaining early approval for further release of funds to reflect priority "straightforward" schemes against agreed criteria and stage two involved concentrating on the wider process and priorities that would underpin the 3/5 year capital plan.

ACTION BY

As this was the first year in which the responsibility had been devolved to NHS Boards, Mrs Hull also set out future processes for agreeing a 3/5 year capital plan. As there was some urgency in releasing funds in year, the Board was asked to approve the release of a further £15.2M capital funds in 2002/03. This would leave £8M to be finally allocated once further work on capital planning processes was complete.

Dr Hughes referred to the proposal to refurbish the intensive care unit at Glasgow Royal Infirmary. Mr Divers confirmed the priority of this scheme and advised that a subsequent paper would be considered by the NHS Board which would include this proposal.

Mr P Hamilton referred to the significant implication costs, pan Glasgow, in relation to the Disability Act and various Health and Safety ramifications. This point was acknowledged and Ms Crocket advised that in terms of the Primary Care Trust, allocation funds had been set aside for this purpose for Health Centres and Clinics across Greater Glasgow. Ms Boyle advised that North Glasgow University Hospitals NHS Trust had not made a specific request for this purpose but the capital allocations received to date reflected necessary refurbishing and upgrading requirements.. **Chief Executive**

DECIDED:

- That the further release of £15.2M capital funds in 2002/03 be approved. **Director of Finance**
- That the retention of the remaining £8M for release following further consideration of the acute strategy requirement and related priorities in 2002/03 be noted.
- That the process for agreeing a 3/5 year capital plan be submitted to the NHS Board by the end of the year for approval.

92. 2002/03 FINANCIAL MONITORING REPORT FOR THREE MONTHS ENDED JUNE 2002

A report of the Director of Finance [Board Paper No 02/56] was submitted asking the Board to confirm the 2002/03 Trust Startpoint Allocations as set out in Annex 1 (page 58 of the Board Papers) as the basis for the in-year financial monitoring and to note the results reported for the first quarter, the three months ended 30 June 2002.

Mrs Hull advised that the report confirmed that the decisions made at the May 2002 Board meeting had been consolidated into Trust 2002/03 Startpoint Revenue Allocations. She summarised the financial performance for the three months ended 30 June 2002 as reported by each Trust. At this early stage in the year, the forecast outturn for NHS Greater Glasgow remained break-even at the year end.

In North Glasgow, Ms Boyle reported a deficit of £366K for the period against a planned deficit of £313K. The implementation of saving programmes was placed more heavily towards the latter part of the year and would result in a balanced position being achieved for the full year. In common with other Glasgow Trusts, the annual level of monies from non Glasgow Boards was not fully agreed and, therefore, presented some risk.

ACTION BY

In South Glasgow, Mr Calderwood reported a surplus of £32K against a planned break-even position. Overspending in supplies, particularly pharmacy, was more than offset by underspending caused by a significant number of staff vacancies. As the year progressed it was anticipated that many of the vacancies would be filled and that this could create pressure on the achievement of break-even.

At Yorkhill Trust, Mr Best reported a surplus of £568K against the break-even target for the months to June 2002. This compared unfavourably with the budget surplus of £836K. This shortfall was largely the result of overspending in pharmacy supplies. This needed careful review at the Trust to establish if this overspend was the result of an atypical pattern of expenditure which would return to a more normal patter in future months. On this assumption, the Trust was forecasting a break-even position for the full year.

At the Primary Care Trust, Mr Robertson reported that expenditure in the Mental Health and Learning Disabilities divisions was in line with plan and it was expected to continue this way throughout the year. At this early stage, there was little information on primary care expenditure to support forecasts for the year. Early indications on prescribing expenditure for April showed higher than planned values. This was being closely analysed and further months' spend would allow realistic trends to be established. Subject to the outcome on prescribing expenditure, the Trust continued to forecast break-even for the year.

DECIDED:

- That the 2002/03 Trust Startpoint Allocations as set out in Annex 1 (page 58 of the Board papers) as the basis for the year financial monitoring be confirmed. **Director of Finance**

- That the results reported for the first quarter, the three months ended 30 June 2002 be noted.

93. MENTAL HEALTH (SCOTLAND) ACT 1984 - LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 02/57] was submitted seeking approval of three medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984:

Dr Aziz Manzar
Dr Terrence Burke
Dr Shamsul Jaigirdar

Director of Public Health

94. ETHICS COMMITTEE MINUTES - 7 JUNE 2002

The Minutes of the Greater Glasgow NHS Board Ethics Committee meeting held on Friday 7 June 2002 [GGNHSBEC(M)02/1] were noted.

ACTION BY

95. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES - 25 JUNE 2002

The Minutes of the Greater Glasgow Health and Clinical Governance Committee [Board Paper No 02/58] held on Tuesday 25 June 2002 were noted.

Professor Farthing referred to the link between the Area Clinical Effectiveness Committee and the Health and Clinical Governance Committee. It was recognised that clinical effectiveness was a subset of clinical governance and, therefore, should become a Subcommittee of the Health and Clinical Governance Committee.

96. AUDIT COMMITTEE MINUTES - 23 JULY 2002

The Minutes of the Audit Committee meeting held on 23 July 2002 [A(M)02/3] were noted.

Meeting ended at 11.10 am

GGNHSB(M)02/10
Minutes: 97 - 108

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 0YZ on Tuesday, 17 September 2002 at 9.30 am

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P R E S E N T

Professor G C A Dickson (in the Chair)

Mr J Best	Mr T A Divers OBE
Dr H Burns	Professor M Farthing
Mr R Calderwood	Councillor J Handibode
Mr R Cleland	Dr R Hughes
Councillor D Collins	Mrs W Hull
Ms R Crocket	Mr A O Robertson
Mr T P Davison	Mrs S Kuenssberg CBE

Mrs E Smith

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

Ms E Borland	..	Acting Director of Health Promotion
Mr J Crawford	..	Principal Health Promotion Officer (to Item 101)
Mr T Findlay	..	Divisional General Manager, Primary Care NHS Trust (to Item 102)
Dr R Gardee	..	Consultant in Public Health Medicine, Primary Care NHS Trust (to Item 101)
Mr J C Hamilton	..	Head of Board Administration
Ms C Renfrew	..	Director of Planning and Community Care
Mr B Steven	..	Director of Finance, North Glasgow University Hospitals NHS Trust
Dr I Wallace	..	Medical Director, Primary Care NHS Trust (to Item 102)
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mrs C Anderson	..	Chair, Area Pharmaceutical Committee
Mr P Hamilton	..	Convener, Greater Glasgow Health Council
Mr S Haslem	..	Director, FMR Consultants (to Item 100)
Dr J Nugent	..	Chair, LHCC Professional Committee
Mr H Smith	..	Chair, Area Professions Allied to Medicine Committee (AHPs)

ACTION BY

97. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Ms M Boyle (Chief Executive, North Glasgow University Hospitals NHS Trust), Councillor Robert Duncan, Mr W Goudie, Councillor John Gray, Dr F Marshall, Dr F Angell (Chair, Area Dental Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mr E P McVey (Chair, Area Optometric Committee) and Ms S Plummer (Nurse Adviser).

The Chairman welcomed Brian Steven, Director of Finance, North Glasgow University Hospitals NHS Trust, to the meeting.

98. INTERIM CHAIRMAN'S REPORT

The Chairman advised that he had recently met with the Scottish Executive – Strategic Change Unit to conduct an evaluation of the development of the NHS Board. Good progress had been made and further national direction would be provided once all NHS Boards' results had been analysed.

The Chairman referred to the debate and motions in the Scottish Parliament last week on the NHS Board's Acute Services Strategy. The NHS Board's proposals were supported and now it was time to collectively go forward in implementing the very necessary changes required to Glasgow's Acute Hospital Services.

99. MINUTES

On the motion of Mr A O Robertson, seconded by Dr R Hughes, the Minutes of the meeting of the NHS Board held on Tuesday, 20 August 2002 [GGNHSB(M)02/09] were approved as an accurate record and signed by the Chairman.

100. PROPOSALS FOR EARLY MOVE OF INPATIENT SPECIALTIES WITHIN GREATER GLASGOW – OUTCOME OF CONSULTATIONS

A report of the Chief Executive and Public Affairs Manager [Board Paper No. 02/59] was submitted on the outcome of the Board's consultation on the future of in-patient Ophthalmology; Ear, Nose and Throat Services; Gynaecology/Gynaecological Oncology Services in North-East Glasgow; and in-patient services for Dermatology across NHS Greater Glasgow.

In Spring 2002, the NHS Board had approved the method of consultation for the proposed service changes for each of the 4 clinical specialties.

A Consultation Liaison Group was established to advise on the logistics of the consultation and its membership included:-

- Service Managers of the 4 specialties from North Glasgow University Hospitals NHS Trust
- Service Manager responsible for Dermatology in South Glasgow
- Executive Assistant to the Chief Executive and Chairman of North Glasgow Trust
- Public Affairs Manager, Greater Glasgow NHS Board
- Convener, Greater Glasgow Health Council

Copies of the full consultation papers were distributed to the Board's standard consultation list and to those patients/members of the public who had requested copies following sight of posters, summary leaflets or advertisements. 45,000 summary leaflets were printed and distributed via local libraries, hospital and GP waiting areas, pharmacies, dental and opticians' practices, Health Council, and were sent to members of the public and patients on request. The consultation papers and leaflets were translated into Cantonese, Punjabi and Urdu and made available in braille, large print and tape format.

In addition, 500 A3 posters were distributed, adverts taken in newspapers, letters appeared in the Herald and Evening Times at the launch of consultation, together with a press release to all media outlets.

The proposals were contained in the NHS Board's website. Staff meetings were undertaken by the North Glasgow Trust, together with a meeting with the North Glasgow Patients Forum. A quantitative and qualitative survey of patients and the public was undertaken by FMR Consultants of Glasgow which included a full representative sample of 400 members of the public in the communities affected by the proposals and a sample of 404 patients from the 4 clinical specialties. A patient focus group was organised and the Consultation Liaison Group convened regularly to manage this process.

A total of 43 written responses to the consultation were received and these had been summarised for members in the papers submitted, together with copies of the full responses being available to members at the NHS Board meeting. A late response had been received from Mr P Martin MSP and this was circulated to members.

The balance of comments submitted on each of the strategies largely supported the strategic thrust behind the proposals. Issues were raised, however, on the following points:-

- Confirmation of the adequacy of bed numbers within Dermatology and Gynaecology.

- Reassurances that the planned bed provision would not impact adversely on waiting times.

- Development of a joint approach with Strathclyde Passenger Transport Executive on improving transport links for the whole of the strategy for acute services.

- Reassurance through detailed staffing plans for each specialty that an adequate level of resources was available to ensure high quality care within each in-patient centre.

Mr Divers advised that consistent with the commitment given by the former Minister for Health and Community Care, there had been no changes to acute services at Stobhill prior to Ministerial approval of the Acute Services Review. The overall strategy had now been approved and the proposals consulted upon were clinically-led changes required to in-patient services. Out-patient and day cases would remain unchanged with the exception of Head and Neck Cancer ervices which would transfer to the Beatson Oncology Centre.

In reply to a point raised by the Health Council on the consultation, Mr Divers advised that Dermatology out-patient services would be provided from all four ambulatory care centres.

Simon Haslem, Director, FMR Consultants, gave a presentation to Board Members on the outcome of the quantitative and qualitative survey of members of the public and patients of the acute specialties and highlighted the following:

- A high proportion of members of the public (68%) and patients (43-55%) were not aware that acute hospital services in Greater Glasgow were undergoing change and review.

- The majority of the public and patients indicated that the quality of care received was more important than ease of access to in-patient or out-patient facilities.

- The majority of patients and members of the public preferred children to be treated at a specialist children's hospital rather than the nearest adult acute site.

ACTION BY

- The majority of patients and public supported the proposed changes to the 4 acute specialties.

- The greatest single issue of concern was public transport access to in-patient and out-patient hospital services.

- The significant change that the public and patients wanted to the proposals was to find a way of improving public transport provision.

- There was a high level of praise for the quality of service provided by staff in the NHS Trusts.

In reply to Cllr Collins' question about showing numbers and not just percentages and following up on all those surveyed, Mr Haslem confirmed that the main report showed the numbers against each question. Also, other than the question about awareness of changes and priorities, all patients and members of the public surveyed were asked all remaining questions.

Cllr McCafferty did not feel that the survey was conclusive and hearing from the general public and local communities about the changes in acute services was far more important. It had been a comprehensive approach to consultation but the real test was whether the NHS Board would have been prepared to alter its proposals if the findings had not supported the proposed changes.

The Chairman indicated that the survey had been only one element of the consultation process and the NHS Board's decision would not be based on the survey alone.

Dr Nugent was pleased with the findings of the survey and the fact that the predominant view from the public and patients was that the proposed changes would lead to improved standards of care offered to patients.

Mr Hamilton commented that he had been pleased to be a member of the Consultation Liaison Group. The consultation document had not been explicit about the location of the new Dermatology Centre at the Southern General Hospital. He was now aware that the interim location before construction of the new centre would be in the Langlands Building.

On issues around the utilisation of the accommodation vacated at the Western Infirmary, possible interim moves for Gynaecology at Stobhill, clinical benefits of the transfer of Head and Neck Cancer from Stobhill and the need to ensure any accommodation used was better than current provision, Mr Divers agreed that the Health Council would be included in the dialogue for these and the other points raised during consultation.

DECIDED:

1. That the outcome of the consultation for the proposals to change ENT, Gynaecology and Ophthalmology Services in hospitals in north and east Glasgow and Dermatology Services across Greater Glasgow be noted, and that the predominant view from the survey was that the proposed changes would lead to an improved standard of care offered to patients.

2. That the proposal that Ear, Nose and Throat Services in north and east Glasgow be reconfigured through provision of an in-patient centre of excellence at Gartnavel General Hospital, provision of out-patient care from Stobhill and Gartnavel General Hospitals plus the Glasgow Royal Infirmary and that all children requiring ENT care should be treated at the Royal Hospital for Sick Children, be approved. **Chief Executive**

ACTION BY

3. That the proposal that Gynaecology Services in north and east Glasgow be reconfigured through the construction of a dedicated in-patient facility at Glasgow Royal Infirmary and that Gynaecology out-patient and day care should be provided from Stobhill Hospital, Glasgow Royal Infirmary and Gartnavel General Hospital, be approved. **Chief Executive**

4. That the proposal that Ophthalmology Services in north and east Glasgow be reconfigured through transfer of Stobhill Hospital's in-patient beds to an in-patient centre of excellence to be located at Gartnavel General Hospitals and that out-patient and day case services continue to be provided from Stobhill, Gartnavel and Glasgow Royal Infirmary, be approved. **Chief Executive**

5. That the proposal that Dermatology Services across Greater Glasgow be reconfigured through the provision of a core Dermatology in-patient centre at the Southern General Hospital; that this centre would be augmented by a network of Ambulatory Dermatology centres, of which one would be located at the Stobhill Ambulatory Care Hospital and one at the Victoria Ambulatory Care Hospital, and that a Paediatric Dermatology Service be located at Yorkhill NHS Trust, be approved. **Chief Executive**

6. That the Chief Executive of the NHS Board submit the proposed changes to the Minister for Health and Community Care for approval. **Chief Executive**

101. RACE EQUALITY POLICY – OUTCOME OF CONSULTATION

A report of the Principal Health Promotion Officer [Board Paper No. 02/60] was submitted detailing the outcome of the 3-month consultation process undertaken on the Draft Race Equality Policy for NHS Greater.

The consultation process involved:-

- Distribution of the consultation documentation to the Board's standard list of consultees and 162 black and ethnic minority organisations.
- A seminar for black and ethnic organisations in NHS Greater Glasgow area was held on 20th August – 50 people representing 39 organisations attended the seminar.
- 16 focus groups were commissioned spanning the range of black and ethnic minority communities in NHS Greater Glasgow area.
- The consultation document was made available in the main community languages in both written and tape format.

16 comments were received and, as a result of these comments, the policy had been updated and submitted to the NHS Board for approval.

DECIDED:

1. That the Race Equality Policy be approved. **Principal Health Promotion Officer**

2. That the actions to implement the Race Equality agenda, as detailed in the Board Paper [02/60], be approved. **Principal Health Promotion Officer**

ACTION BY

102. ACCESS TO PRIMARY CARE

A report of the Chief Executive, Greater Glasgow Primary Care NHS Trust [Board Paper No. 02/61] was submitted setting out the current position within NHS Greater Glasgow to the commitment given in 'Our National Health' that patients gain access to an appropriate member of the primary health care team within 48 hours.

Mr Davison introduced Terry Findlay, Divisional General Manager, and Iain Wallace, Medical Director, of the Greater Glasgow Primary Care NHS Trust.

NHS Boards were required to submit a strategy and target date for achieving 48-hour access to the Scottish Executive Health Department by 20 September 2002.

Greater Glasgow's Primary Care Strategy provided a long term direction and investment plan for improving capacity and access to services. Initial work commenced on gathering information, testing new approaches and focusing on short term actions to achieve the 48-hour target. Pending the outcome of the preliminary work, a target date of implementing the 48-hour access target had been set as April 2004; this would be reviewed as the strategy was fully developed and costed.

The paper set out the long term initiatives towards 'Increasing Capacity', the medium term initiative towards 'Managing Demand and Service Re-design' and the short term initiatives towards 'Assessment, Triage and Practice Re-design'.

Based on the results of the first phase of practice, re-design pilot triage and data collection, a fully developed and costed strategy would be prepared and submitted to the NHS Board in March 2003.

DECIDED:

1. That the strategy set out in Section 4 of the Board Paper [02/61] for achieving improved access and achieving the 48-hour target for Primary Care Services, be endorsed. — **Chief Executive, Primary Care Trust**

2. That the Action Plan for achieving and monitoring the 48-hour access target for Primary Care, be endorsed. — **Chief Executive, Primary Care Trust**

3. That a fully developed and costed strategy be submitted to the NHS Board in March 2003. — **Chief Executive, Primary Care Trust**

103. FINANCIAL MONITORING REPORT FOR 4 MONTHS ENDED JULY 2002

A report of the Director of Finance [Board Paper No. 02/62] was submitted setting out the financial position for the four months ended July 2002.

The Director of Finance reported that the forecast out-turn for NHS Greater Glasgow remained break-even at the year end, but she explained that a further analysis of the in-year position would be undertaken as part of the Mid-Year Review, due to be with the Board at its November meeting.

Cllr Handibode sought further information on the reported deficit for Yorkhill NHS Trust. Mr Best advised that the deficit was largely the result of overspending in pharmacy supplies – specifically on increased volume of drugs for cancer patients and the one-off purchase of instruments. Detailed plans were being developed to ensure that expenditure was brought in line with the budget available in the course of the year.

NOTED

ACTION BY

104. WAITING TIMES AND STANDARDS 2002/03

A report of the Director of Planning and Community Care [Board Paper No 02/63] was submitted setting out the plans to ensure that a 50% reduction for in-patients with a guaranteed wait of under 9 months was achieved by the end of March 2003 and that no in-patient with a guarantee waited over 9 months by the end of December 2003.

Attached to the Board paper was the Report to the National Waiting Times Unit (NWTU) which described how these two targets could be met, together with the letter from the Minister for Health and Community Care emphasising the importance of achieving the targets.

Table 3 of the report identified that of the 1625 patients waiting over 9 months for in-patient treatment at the end of June 2002, 706 were exempt from the guarantee. These were patients who were not ready to take up their appointment or wanted to wait for a particular specialist; they did, however, require to be treated, as did those on deferred waiting lists. Both these issues were subject to a National Review.

Ms Renfrew referred to some of the risks associated with delivering the targets, namely: the impact of nurse staffing problems, emergency activity levels increasing thereby affecting the ability to sustain the planned elective workload, growth in waiting list numbers and medical staffing issues. Orthopaedics waiting list numbers continued to grow, especially in the South Acute Trust where there had been breaches of the 12-month guarantee during the summer.

In answering a question from Cllr McCafferty, Ms Renfrew stated that with the National Waiting Times Centre at Clydebank already staffed, this had been a helpful addition, although there remained the issue of its possible expansion and need for further staff. Cllr McCafferty asked that an overall assessment of the opening of the National Waiting Times Centre be prepared for the Board at a future date.

Members had some concerns about how the targets could be fully achieved and sustained, but recognised the NHS Board's responsibility in meeting the targets and offering its residents the same access to care as all other patients in Scotland.

It was emphasised that in developing Action Plans, clinical staff needed to be part of the process and gain ownership to the solutions as they were required to deliver the targets.

The NHS Board had committed £5.4 million funding to tackling waiting lists and the Trusts had already agreed the additional activity. It was a challenge for the NHS Board, but it was a key priority for the NHS Board in the next year. A report would be prepared for the next meeting of the NHS Board showing specific actions to achieve the targets, clinical support and an analysis of what the current staffing and capacity within NHS Greater Glasgow could sustain. Regular monthly monitoring reports would continue to be submitted to the NHS Board on the progress of meeting the targets set. **Director of Planning and Community Care**

The Chairman would respond to the Minister's letter on behalf of the NHS Board on delivering the agreed targets and timescale for achievement. **Chairman**

NOTED

ACTION BY

105. QUARTERLY REPORTS ON COMPLAINTS AND OMBUDSMAN'S REPORT

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No. 02/64] was submitted setting out the Quarterly Report on Complaints in NHS Greater Glasgow for the period 1 April to 30 June 2002 and details of the Annual Report of the Scottish Parliamentary Ombudsman and the Health Service Commissioner for Scotland – 2001/02.

NOTED

106. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 02/65] was submitted seeking approval of one medical practitioner employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioner be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Janet Fellowes

107. RESEARCH ETHICS GOVERNANCE COMMITTEE MINUTES: 2 AUGUST 2002

The Minutes of the meeting of the Research Ethics Governance Committee held on 2 August 2002 [NHSGGREGC(M)02/2] were noted.

108. STAFF GOVERNANCE COMMITTEE:

(i) Staff Governance Committee – Procedural Issues

A report of the Head of Board Administration [Board Paper No. 02/66] was submitted seeking an amendment to the remit of the Staff Governance Committee and approval of the Membership of the Remuneration Sub-Committee.

DECIDED:

1. That the minor amendment to the Remit of the Staff Governance Committee be approved. **Head of Board Administration**

2. That the Employee Director be appointed to the Remuneration Sub-Committee and a Non-Executive Director be appointed to chair the NHS Board's Remuneration Group. **Head of Board Administration**

(ii) Minutes of the Staff Governance Committee: 3 September 2002

The Minutes of the meeting of the Staff Governance Committee held on 3 September 2002 [GGNHSBSGC(M)02/1] were noted.

The meeting ended at 11.15 a.m.

GGNHSB(M)02/11
Minutes: 109 - 122

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 22 October 2002 at 9.30 am**

P R E S E N T

Professor G C A Dickson (in the Chair)

Mr J Best	Mr T A Divers OBE
Dr H Burns	Councillor R Duncan
Mr R Calderwood	Mr W Goudie
Mr R Cleland	Dr R Hughes
Ms R Crocket	Dr F Marshall
Mr T Davison	Councillor D McCafferty

Mrs E Smith

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

Dr A Bryson	Medical Director, Beatson Oncology Centre (to Minute 123)
Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr J M Hamilton	Assistant Director of Finance
Mr A Lindsay	Head of Control and Support Services (from Minute 113)
Ms C Renfrew	Director of Planning and Community Care
Mr I Reid	Acting Chief Executive, Greater Glasgow Primary Care NHS Trust
Mr J Whyteside	Communications Manager

B Y I N V I T A T I O N

Dr F Angell	Chair, Area Dental Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Ms M Nutter	Representative, Area Professionals Allied to Medicines Committee (AHPS)

G U E S T P R E S E N T E R S - N H S 2 4 (TO MINUTE NO 111)

Ms C Campbell	Regional Project Manager for the West
Ms C Lenihan	Chairman
Ms E Muir	Deputy Director of Nursing
Ms M Regan	Director of Communications
Dr B Robson	Medical Director

ACTION BY

109. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Councillor D Collins, Professor M Farthing, Councillor John Gray, Councillor J Handibode, Mrs W Hull, Mrs S Kuennsberg CBE, Mr A O Robertson, Mrs C Anderson (Chair, Area Pharmaceutical Committee), Ms E Borland (Acting Director of Health Promotion), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mr E P McVey (Chair, Area Optometric Committee), Dr J Nugent (Chair, LHCC Professional Committee), Ms S Plummer (Nurse Adviser to the Board) and Mr H Smith (Chair, Area Paramedical Committee).

The Chairman welcomed Mr Ian Reid, Acting Chief Executive of Greater Glasgow Primary Care NHS Trust to his first NHS Board meeting. He also welcomed the guest speakers from NHS 24.

110. MINUTES

On the motion of Mr J Best, seconded by Mr R Calderwood, the Minutes of the meeting of the NHS Board held on Tuesday 17 September 2002 [GGNHSB(M)02/10] were approved as an accurate record and signed by the Chairman pending the following amendment:.

- The addition of Councillor D McCafferty to the list of Board Members present.

NOTED

111. NHS 24 PRESENTATION

Dr Brian Robson, Medical Director, NHS24, described the new clinical service for Scotland in terms of improved access to health information via telephone nurse consultations. There were three leading edge contact centres in Scotland – in Aberdeen, Clydebank and South Queensferry.

NHS 24 was not a replacement of any health service but a complementary service which was convenient to patients, equitable across Scotland and provided 24 hours a day. This provided an opportunity for people to get the most appropriate care maximizing the use of other health professionals (for example pharmacy) and reducing inappropriate workload on the NHS.

Dr Robson referred to the experience gained in Grampian where the service was provided to 575,000 people in urban, remote and rural areas. Much of the success of NHS 24 in Grampian could be attributed to the joint working between G-DOCS (the equivalent of Greater Glasgow's GEMS), Scottish Ambulance Service, two A & E Departments and 20 community hospitals. The centre received, on average, around 2,000 calls per week – 98% of which are answered in less than 30 seconds. The average call duration was 12 minutes and the outcome for out of hours calls could be broken down as follows:

- 3% referred to the Scottish Ambulance Service
- 6% referred to an A & E
- 60% referred to the GP G-DOC service

Dr Robson described how the service would work in Greater Glasgow by highlighting the following:

- night-time – all calls directed previously to GEMS would automatically be answered by NHS 24;

- day-time – people should still contact their GPs as normal;

- additional capacity – NHS 24 would bring an additional capacity of a 24 hour nurse consultation service and health information service.

In terms of working with NHS Greater Glasgow, Dr Robson confirmed that partnership working had taken place with GEMS, the Scottish Ambulance Service, Acute Services, Accident & Emergency, Primary Care and Dentistry in an effort to maximise benefit to patients. It was their intention to continue such close working with NHS Greater Glasgow when NHS 24 went live mid November. Prior to the service getting up and running, they were working on promoting public awareness and understanding of the service and this would be done via TV and radio advertisements as well various posters and leaflets distributed throughout the city. Dr Robson thanked NHS Greater Glasgow for its support, commitment and hard work, making it possible to launch NHS 24 in Glasgow in November 2002.

Professor Dickson thanked Dr Robson and his team for an interesting and informative presentation.

Mr P Hamilton asked how seamless the transfer would be from GEMS to NHS 24. Dr Robson confirmed that both GEMS and NHS 24 were committed to providing a seamless transfer and that members of the public would be informed via publicity campaigns that, out of hours, all their calls would be answered by NHS 24. Given that Dr Robson had referred to the average call duration time being 12 minutes, he further clarified that the centre would not operate to a "target call time" – there was a detailed system of questioning which would be tailored to fit the needs of individual calls regardless of how long they may take. Ms Regan highlighted the experiences learned from the introduction of the service in NHS Grampian in terms of communicating with the whole population including ethnic communities, deaf communities and raising awareness amongst the visually impaired. She was confident that given the NHS Grampian experiences this would be a smooth transitional phase in Greater Glasgow.

Professor Dickson referred to the valued relationship Greater Glasgow NHS Board had with Greater Glasgow Health Council and encouraged NHS 24 to build on this good relationship in Glasgow in terms of communicating with users of the service. Ms Regan confirmed that NHS 24 had already met with Greater Glasgow Health Council and would most definitely continue this dialogue.

In response to a question from Councillor McCafferty, Mrs Muir confirmed that the skill mix of nurses was very broad based and incorporated into their core training was dealing with mental health issues and critical decision making skills. Furthermore, referral of mental health issue related calls could be handed over to community psychiatric nurses (CPNs).

ACTION BY

Dr Hughes voiced concern regarding the impact of nurse recruitment to NHS 24 from the acute sector. Mrs Muir advised that two-thirds of NHS 24's nursing staff had already been recruited and recognized that 51% of these nurses had come from the acute sector – this was largely due to their appointment criteria which stipulated that nurses should have at least five years general nursing experience.

In response to a question from Dr Marshall, Ms Regan confirmed that NHS 24 would provide a "call back" system in the event of patients calling from pay phones or mobile phones.

Professor Dickson and the Board looked forward to these services going live in Greater Glasgow in November and wished the team well for the challenges that lay ahead.

NOTED

112. BEATSON ONCOLOGY CENTRE – AN UPDATE OF ACTION PLAN

A report of the Chief Executive [Board Paper No 02/67] was submitted asking the Board to note the update of progress in implementing the action plan and to authorise production of a further quarterly update for the January 2003 Board.

Mr Divers referred to the detailed update of progress attached at Annex 1 of the Board paper. He led the Board through the key areas of development and introduced Dr Adam Bryson, Medical Director, Beatson Oncology Centre.

An interview date would be set for November 2002 with a view to filling the appointment of Medical Director. There had been a strong UK wide and international interest in this post. The overall staffing position within the Beatson Oncology Centre continued to improve with the total number of staff projected to be in post at 4 November 2002 being 439.78 WTE, some 73.14 WTE higher than the position at January 2002. Significant pressure continued on Consultant Clinical Oncologist staffing, however, with no applications received in response to the further recruitment exercise undertaken during the summer. Efforts continued to identify potential applicants for Consultant Oncologist vacancies through local and international recruitment agencies.

Work on the West of Scotland Plan for Specialist Oncology Services progressed materially during the last four months. The process completed its first stage in June 2002 and on the basis of that work, proposals for the future pattern of Specialist Oncology Services across the West of Scotland had now been shared with each NHS Board. Discussion would be ongoing so that a future pattern of Specialist Oncological care could be finalized by the target date of 1 April 2003.

The Phase II Business Plan Development was one of the first three critical projects in implementing the Board's Acute Services Strategy. As such, a final review of the project's scale and affordability (alongside the development of the two Ambulatory Care Hospitals) was in progress. The Board required to be assured that all three projects remained affordable and deliverable within the timescale set out in the Board's Acute Services Plan.

Dr Bryson highlighted other key areas of progress including the following:

- Meetings had taken place with site management tumour teams to move towards greater comprehensive use of IT.

ACTION BY

- Additional revenue requirements for April 2003 had been calculated in relation to the funding provided to address the deficits in staffing, facilities and other resources.

- Beatson Oncology Centre was continuing to actively recruit, retain and provide continuing personal development programmes for staff.

- Work was ongoing in the production of an education strategy.

- Significant progress had been made on producing a comprehensive IT strategy. This was being developed to ensure that the move to the new Cancer Centre in four years time would facilitate the IT strategy.

In response to a question from Dr Hughes, Dr Bryson recognised that Consultant Clinical Oncologists were still working under pressure, taking on 450 new patients per annum per Consultant (the guidelines were 320 new patients). While this was not out of step with some other parts of the UK the pressures remained material.

Dr Bryson recognised the importance of demonstrating to potential candidates that the Beatson Oncology Centre was an attractive place to work and was reassured that out of the two appointment panels conducted for Oncologists at the Beatson, successful appointments had been made. This point was re-iterated by Councillor McCafferty who highlighted the importance of being self-analytical and being more innovative in encouraging applicants to come to Glasgow as a career move. This had to be seen in the backdrop of there being a shortage nationally of Consultant Clinical Oncologists.

In a response to a question from Mr P Hamilton, Dr Bryson confirmed that ongoing training was being given to developing management arrangements and skills and the Beatson Oncology Centre was working hard to improve its management structure.

Dr Burns referred to a visit carried out at the Beatson Oncology Centre by Cancer Research UK – it had given the highest possible grading to the Beatson Oncology Centre for quality of service in science and such academic developments were very positive and encouraging.

Mr Cleland sought clarity around the timescales for the development of the project involving the Phase II development of the Beatson Oncology Centre and the two Ambulatory Care Hospitals. Mr Divers confirmed that the next Acute Services Steering Group meeting was scheduled for the following week when Members would be looking at the totality of the plan and taking stock and revisiting the overall financial framework.

Professor Dickson thanked Dr Bryson for an encouraging update report and once again highlighted the importance of making Glasgow, in general, an attractive career option for both medical and nursing posts.

DECIDED:

- That the update of progress in implementing the action plan be noted. **Chief Executive**

- That a further quarterly update of the action plan be submitted to the Board meeting in January 2003. **Chief Executive**

ACTION BY

113. WINTER PLAN 2002/2003

A report of the Director of Planning and Community Care [Board Paper No 02/68] was submitted summarizing the Winter Plan 02/03 and asking the Board to note the proposed resource allocation and areas of risk and pressure.

Ms Renfrew explained that each local health system was required to submit a Winter Plan to the Scottish Executive by the end of October 2002. The key objectives of winter planning were to ensure that:

- Patients could be admitted through assessment facilities to a bed in the appropriate specialty.
- Long delays for patients waiting for admission from Accident and Emergency were avoided.
- Restrictions on admissions to hospitals were minimised.
- Transfer of patients between intensive care facilities was minimised.
- Flu vaccination among vulnerable patients and staff was maximised.
- Appropriately rapid discharge and alternatives to admission, where appropriate, were achieved.
- Elective activity was maintained.

The development of plans to deliver on these objectives had two elements of process.

- Each Trust had its own Winter Planning Group, bringing together the key players, including Social Work and the Ambulance Service.
- A Greater Glasgow Winter Planning Group brought together the Chairs of Trust Groups with the Planning Directorate.

The Scottish Executive Health Department had traditionally allocated non recurring funding for winter pressures and the Board had been notified at the end of September 2002 of an additional £2.3M allocation – the allocation of which had already been endorsed by the Winter Planning Group. These resources were in addition to allocations of £600K and £400K to the North and South Trusts, respectively, made from the Board's additional delayed discharge funding. The planned allocation of additional funding from the delayed discharge monies, at the start of the year, coupled with the rapid release of the Scottish Executive's non recurring allocation against identified Trust priorities, had put the Board in the best possible position to address anticipated winter pressures.

In response to a question from Dr Hughes, Mr Divers confirmed that the Business Plan for the Glasgow Royal Infirmary, ICU development and, in particularly, the capital planning of this was a strategic priority.

In response to a question from Dr Marshall, Ms Renfrew confirmed that joint planning had taken place with the formation of the winter plan and Social Services were committed to its execution. This demonstrated integrated team working and joint team endeavours.

ACTION BY

DECIDED:

- That the Winter Plan 2002/2003 be noted. **Director of Planning & Community Care**

- That the proposed resource allocation and areas of risk and pressure be noted. **Director of Planning & Community Care**

114. GEOGRAPHICAL INEQUALITIES IN ACCESS TO CORONARY ANGIOGRAPHY

A report of the Director of Public Health [Board Paper No 02/69] was submitted asking Members to note the geographical equity of access to elective coronary angiography.

Coronary angiography was used to assess the severity of coronary artery disease so that informed decisions could be made about whether a patient required coronary revascularisation and whether this should be done by cardiac surgery or balloon angioplasty. In 1995/96, the Board demonstrated inequalities in access to coronary angiography across Glasgow with no obvious correlation between need and investigation. Furthermore, some areas with the highest risk of death from ischaemic heart disease had the lowest coronary angiography rates. As a direct result of this survey, additional resources were provided to Trusts to increase coronary angiography capacity. GPs were also encouraged to refer patients with CHD for investigation.

The survey was repeated using data from 1999 to demonstrate whether inequalities had reduced. In this survey, angiography was equitably distributed in relation to need.

Dr Burns highlighted four key conclusions.

- In 1995/96, access to coronary angiography was unequal and bore little relation to apparent needs. There was evidence of the inverse care law whereby those with greatest need were least likely to be investigated and, therefore, considered for coronary revascularisation.

- Across Greater Glasgow as a whole, the overall number of coronary angiograms had increased. This was in line with trends in other areas in Scotland and the rest of the UK.

- Targeted provision of resources and encouraging GPs to refer appropriate patients had achieved the desired effect of reducing inequalities in investigation.

- The overall increase in numbers and greater equality had not been achieved at the expense of waiting times – waiting times were now all within the twelve week maximum recommended by the Scottish Executive and most patients wait considerably less than twelve weeks.

In response to a question from Mr P Hamilton, Dr Burns confirmed that the figures used had been based on those patients attending the Western Infirmary and Glasgow Royal Infirmary. Figures were not used from the HCI and Ross Hall Hospitals as the majority of referrals were made, in Glasgow, to the Western Infirmary and Glasgow Royal Infirmary.

ACTION BY

Dr Marshall commended the Chronic Disease Management Teams who had also worked hard, in parallel, to get rapid access teams in place throughout the city.

NOTED

115. COMMUNICATING THE ACUTE HOSPITAL SERVICES STRATEGY

A report of the Interim Chairman and Public Affairs Manager [Board Paper No 02/70] was submitted asking the Board to consider the issues and outcome from the Board Seminar workshop of 1 October 2002 and discuss whether there was scope to add more to the outline proposals that emerged. Furthermore, a communication strategy would be built and reported to the Board with certain aspects of it commencing immediately.

The Interim Chairman had hosted a Board Seminar workshop on 1 October communications on the Acute Services Strategy. This was seen in light of the £700M major programme over a ten year period to improve health care provision in Greater Glasgow and how best to inform and include members of the public in these changes.

Discussion had surrounded proposals to address each of the key groups with whom the communication was necessary:

- NHS Greater Glasgow's staff
- The general public
- Elected representatives
- The media

Councillor McCafferty re-iterated that the Board should genuinely try to involve people as the strategy unveiled. Given the ten year timescale, things may invariably not go as planned and it was important to be honest about wrong judgments as well as good ones – transparency, openness and honesty must be at the forefront of any communication strategy.

Ms Nutter sought inclusion of mention of the peripheral sites which formed part of the Trusts rather than simply referring to the Trusts by name.

Mr P Hamilton asked that the Board consider naming spokespeople when addressing the media rather than using the terms currently used - "spokesman/spokesperson".

Professor Dickson agreed to consider these points.

DECIDED:

That the issues and outcome from the Board Seminar workshop of 1 October 2002 be noted and the further points highlighted above be considered, and key elements be commenced immediately with the finalised Communication Plan being reported to the Board.

Interim Chairman/ Public Affairs Manager

ACTION BY

116. DISPOSAL OF LAND AT THE FORMER LENNOX CASTLE HOSPITAL

A report of the Chief Executive of Greater Glasgow Primary Care NHS Trust [Board Paper No 02/71] asked the Board to endorse the Greater Glasgow Primary Care NHS Trust's proposal to enter into an agreement with East Dunbartonshire Council and Lennoxtown Initiative in relation to the disposal of the Trust's landholding at the former Lennox Castle Hospital, Lennoxtown.

Professor Dickson outlined the Board's responsibility which was a governance role in satisfying itself that procedures had been complied with and the risks that had been considered were acceptable.

Mr Davison highlighted this proposal as a further example of partnership working involving a community led initiative alongside the NHS and the Local Authority which could achieve significant benefits. The NHS would benefit from minimizing the risks associated with a large vacant hospital site, participating in the re-investment and regeneration of a local community who had been dependent for many decades on the NHS for economic investment in the area and providing a capital receipt for the replacement of outdated existing facilities in Lennoxtown.

Councillor Duncan confirmed that residents and East Dunbartonshire Council welcomed this arrangement.

DECIDED:

That Greater Glasgow Primary Care NHS Trust's proposal to enter into an agreement with East Dunbartonshire Council and Lennoxtown Initiative in relation to the disposal of the Trust's landholding at the former Lennox Castle Hospital, Lennoxtown was in accordance with existing procedures and the necessary risks had been considered.

Chief Executive, Greater Glasgow Primary Care NHS Trust

117. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 02/72] was submitted asking the Board to note progress on waiting time targets and to further note a draft reply to the Minister for Health confirming that waiting times were regarded as a very high priority.

September figures illustrated a small reduction at Yorkhill and the Acute Trusts, but significant reductions were required to meet the 2002 targets. It was anticipated the additional planned activity should begin to have an impact on this and Trusts were reviewing the durability of the December targets.

Professor Dickson highlighted one additional sentence to the draft letter to the Minister for Health and Community Care which reinforced the potential impact of current pay negotiations.

NOTED

ACTION BY

118. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 02/73] was submitted seeking approval of one medical practitioner employed by Greater Glasgow Primary Care NHS Trust to be authorized for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioner be authorized for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Kim Lim

119. 2002/03 FINANCIAL MONITORING REPORT FOR FIVE MONTHS ENDED AUGUST

A report of the Director of Finance [Board Paper No 02/74] asked the Board to note the results reported for the first five months ended 31 August 2002.

Mr J M Hamilton advised that Trusts were reporting a £241K deficit against the break-even target for the five months to August, against a planned surplus of £187K. Given the degree of risk inherent in Trust startpoint revenue allocations, the results for the first five months were encouraging.

Councillor McCafferty sought clarification on whether the underspend on staff salaries was part of a deliberate strategy. Mr Hamilton advised that no strategy existed and the underspends related to the difficulty in filling vacancies, particularly in nursing.

NOTED

120. GREATER GLASGOW NHS BOARD CORPORATE GOVERNANCE FRAMEWORK

A report of the Chief Executive, Director of Finance and Head of Board Administration [Board Paper No 02/75A] was submitted inviting Members to approve the documentation that made up the Corporate Governance Framework and agree that this was reviewed and submitted to the NHS Board annually in March.

The Audit Committee had held a workshop and a formal meeting on 1 October 2002 to discuss the Corporate Governance Framework. The Board papers had been revised to take account of the suggestions made at the workshop and the Audit Committee meeting. The Audit Committee, therefore, recommended the adoption of the following documents by the NHS Board:

- Standing Orders for the Proceedings and Business of the NHS Board.
- Committee Arrangements and Remits.
- Decisions Reserved for the NHS Board
- Ethical Standards in Public Life – Code of Conduct for Members.

ACTION BY

- Register of Board Members' Interests.
- Standards of Business Conduct for NHS Staff
- Standing Financial Instructions
- Fraud and Corruption Response Plan
- Diary of Governance Events

The Board was additionally asked to note Declarations of Interest made by Members.

DECIDED:

1. That the Declarations of Interest made by Members be noted and form part of the Board Minute as an Appendix. **Head of Board Administration**

2. That the following documents be adopted by the Board: **Head of Board Administration**

   - Standing Orders for the Proceedings and Business of the NHS Board
   - Committee Arrangements and Remits
   - Decisions Reserved for the NHS Board
   - Ethical Standards in Public Life – Code of Conduct for Members
   - Register of Board Members' Interests
   - Standards of Business Conduct for NHS Staff
   - Standing Financial Instructions
   - Fraud and Corruption Response Plan
   - Diary of Governance Events

121. RISK MANAGEMENT STRATEGY

A report of the Director of Finance [Board Paper No 02/75B] asked that the Board approve the Risk Management Strategy. This set out the Strategy of Greater Glasgow NHS Board for the management of risk. Implementation of the Strategy would allow the development of a co-ordinated and effective risk management programme for all services and activities. The NHS Board believed that by approaching the management of risk in a strategic and organised manner, the implications of risk could be reduced to an acceptable level.

Mr Goudie asked that on page 82 of the Board papers, paragraph 2.2, the series of bulletpoints highlighting the areas which the Board is required to focus on included "Organisational Development". **Director of Finance**

DECIDED:

That the Risk Management Strategy be approved. **Director of Finance**

122. MINUTES OF AUDIT COMMITTEE

The Minutes of a meeting of the Audit Committee [A(M)02/4] held on Tuesday 1 October 2002 were noted.

Meeting ended at 11.25 am

GGNHSB(M)02/13
Minutes: 136 - 148

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 17 December 2002 at 9.30 am**

P R E S E N T

Professor Sir John Arbuthnott (in the Chair)

Mr J Best	Professor M Farthing
Dr H Burns	Mr W Goudie
Mr R Calderwood	Councillor J Handibode
Mr R Cleland	Dr R Hughes
Councillor D Collins	Mrs W Hull
Ms R Crocket	Mrs S Kuenssberg CBE
Mr T Davison	Dr F Marshall
Professor G C A Dickson	Councillor D McCafferty
Mr T A Divers OBE	Mr I Reid
Councillor R Duncan	Mr A O Robertson OBE
Mrs E Smith	

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

Dr S Ahmed	Consultant In Public Health Medicine (for Minute 145)
Ms E Borland	Acting Director of Health Promotion
Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Planning and Community Care
Mr J Whyteside	Public Affairs Manager

B Y I N V I T A T I O N

Dr F Angell	Chair, Area Dental Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Dr J Nugent	Chair, LHCC Professional Committee
Mr H Smith	Chair, Area Allied Health Professions Committee
Mrs C Anderson	Chair, Area Pharmaceutical Committee (to Minute 143)

ACTION BY

136. APOLOGIES

Apologies for absence were intimated on behalf of Councillor J Gray, Ms S Plummer (Nurse Adviser to NHS Board) and Mr E P McVey (Chair, Area Optometric Committee).

ACTION BY

137. CHAIRMAN'S REPORT

The Chairman made reference to the following events in which he had been involved since the last NHS Board meeting:

(a) Attendance at the Scottish NHS Chairmen's Group meeting with the Minister on 29 November. Topics of discussion included:

- Waiting Times and the importance of identifying risk factors likely to have an adverse affect on national waiting targets and how to tackle these factors.

- The introduction of the Local Government Bill which included Community Planning legislation and a responsibility on NHS Boards to formalise its arrangements with local authority partners.

- Glasgow Alliance – the evaluation report was in its final stages and would form the basis of a consultation exercise early in 2003 about the future arrangements for community planning and action. It was paramount that the partners worked effectively to move forward the joint agenda.

(b) Attendance, on 3 December, at the Staff Governance Committee meeting. It was agreed that future meetings would be chaired jointly by the NHS Board Chairman and Bill Goudie, Employee Director. The meeting had been very constructive and detailed work planned to ensure staff were involved and engaged with NHS Greater Glasgow. The Chairman also referred to the Remuneration Subcommittee which he had attended on 19 November.

The Chairman referred to the recent public media coverage of the clinical investigation into the tuberculosis (TB) cases in Greater Glasgow. He invited Dr H Burns, Director of Public Health, to update and report on this. Dr Burns firstly commented on the importance in striking a balance between information released to the media and ensuring patient confidentiality. In preparing media releases, it was important to ensure that no information was divulged which could identify an individual patient. Similarly, however, it was important to inform and educate the public in relation to communicable diseases. Dr Burns advised that a protocol and guidelines would be written up regarding pro-active information on communicable diseases working within a legal framework.

The Chairman also made reference to the circulated action sheet which would be issued every month to identify action points following each NHS Board meeting

NOTED

138. CHIEF EXECUTIVE'S UPDATE

Mr Divers updated the NHS Board on the following issues:

(a) At the September 2002 NHS Board meeting, the following decisions were made in relation to the future of inpatient Ophthalmology; Ear, Nose and Throat Services; Gynaecology/Gynaecological Oncology Services in North Glasgow and inpatient services for Dermatology across NHS Greater Glasgow:

ACTION BY

- That Ear, Nose and Throat Services in North and East Glasgow be reconfigured through provision of an inpatient centre of excellence at Gartnavel General Hospital, provision of outpatient care from Stobhill and Gartnavel General Hospitals plus the Glasgow Royal Infirmary and that all children requiring ENT care be treated at the Royal Hospital for Sick Children.

- That Gynaecology Services in North and East Glasgow be reconfigured through the construction of a dedicated inpatient facility at Glasgow Royal Infirmary and that Gynaecology outpatient and day care should be provided from Stobhill Hospital, Glasgow Royal Infirmary and Gartnavel General Hospital.

- That Ophthalmology Services in North and East Glasgow be reconfigured through transfer of Stobhill Hospital's inpatient beds to an inpatient centre of excellence to be located at Gartnavel General Hospital and that outpatient and day case services continue to be provided from Stobhill, Gartnavel and Glasgow Royal Infirmary.

- That Dermatology Services across Greater Glasgow be reconfigured through the provision of a core inpatient centre at the Southern General Hospital; that this centre would be augmented by a network of Ambulatory Dermatology Centres, of which one would be located at the Stobhill Ambulatory Care Hospital and one at the Victoria Ambulatory Care Hospital and that a Paediatric Dermatology Service be located at Yorkhill NHS Trust.

At that time, the Board submitted its proposed changes to the Minister for Health and Community Care for approval. The Minister had now approved the proposals and had asked for further information in connection with the public transport implications of these reconfigurations. Mr Divers advised that this work was underway. Furthermore, arrangements would be made for a seminar with Greater Glasgow Health Council to discuss the public transport survey in relation to the Acute Services Strategy. **Chief Executive**

In response to a question from Dr Hughes, Mr Divers confirmed that theatre, outpatient and office space for ENT and Gynaecology Services was fit for the purpose.

(b) Mr Divers asked that Mr Calderwood update on the low pay concordat plans. Mr Calderwood advised that developments were ongoing in connection with low pay and that UNISON had written raising various issues. A response would be sent addressing these issues by the end of that week. Thereafter, it was proposed that the low pay issues would be considered in totality at a meeting in January 2003.

(c) Neil Campbell from NHS Grampian had been seconded to NHS Argyll and Clyde as Chief Executive. He had made early contact with Mr Divers and arrangements had been made to meet.

In response to a question from Councillor Collins, Mr Divers confirmed that he would highlight the key involvement of local authorities to Mr Campbell ensuring that strategic plans were consistent and that local authorities were involved at an early stage.

NOTED

ACTION BY

139. MINUTES

On the motion of Professor G C A Dickson, seconded by Mr A O Robertson, the Minutes of the meeting of the NHS Board held on Tuesday 19 November 2002 [GGNHSB(M)02/12] were approved as an accurate record and signed by the Chairman.

140. ACCOUNTABILITY REVIEW 2002/2003 : MID YEAR REVIEW OF PROGRESS

A report of the Chief Executive of Greater Glasgow NHS Board [Board Paper No 02/82] was submitted asking the NHS Board to:

- Receive the mid year update of progress in taking forward the priorities agreed at the 2002 Accountability Review meeting with the Scottish Executive Health Department.

- Note that a further update would be provided to the NHS Board in the Board meeting preceding the 2003 Accountability Review meeting.

The NHS Board's Annual Accountability Review meeting had been held on 20 June 2002 with the Chief Executive of NHS Scotland and his senior colleagues. The output from that meeting was set out in a letter dated 10 July 2002 from Trevor Jones, Chief Executive of NHS Scotland and this was included as a paper at the NHS Board's August 2002 meeting and in the Annual Report.

In terms of the mid year update of progress on the six key action points, Mr Divers took each in turn as follows:

(i) Managing Within Available Resources

The financial strategy adopted by the Board in the summer of 2002 was designed to ensure that, by April 2004, the NHS system across Greater Glasgow was in a position of recurrent financial balance. It was essential that financial balance was achieved by that point so that the pool of investment which was required to fund implementation of the Acute Service Strategy could begin to be built up. The Director of Finance's regular monitoring reports to the NHS Board had shown that with the injection of additional resource, allied to the strenuous efforts taken across all NHS Trusts to manage within the monies available, there appeared to be a level of stability to the overall financial position. There remained three particular areas of risk in the remaining months of this financial year:

- The continuing national discussions about the commitment within the Scottish Health Plan to address low pay within NHS Scotland – if the current pay offer was accepted, there would be a part year impact in 2002/2003.

- There may be a level of further funding required to ensure that the March 2003 intermediate waiting time target was delivered.

- Greater Glasgow NHS Trusts had a number of issues outstanding for resolution with some other West of Scotland NHS Boards.

These three issues would be kept under careful review during the remainder of the year. **Chief Executive/ Director of Finance**

ACTION BY

(ii) Managing the Capital Programme to Sustain Implementation of the Acute Services Review

Work on delivering this priority was progressing on three fronts:

- The most urgent was to progress the schemes for the Ambulatory Care Hospitals and for the second phase of the Beatson Oncology Centre redevelopment to enable the Capital Investment Group to consider the Business Cases in late January 2003. The Minister for Health and Community Care had already given the commitment that public funding would be available for the phase two redevelopment of the Beatson Oncology Centre; the expectation was that both Ambulatory Care Hospitals would be procured by public/private sector partnership (PPP).

- Work involving the development of the local Capital Plan for NHS Greater Glasgow. This was vital to progress the Acute Services Strategy and other Board strategies which were dependent on capital investment. The Capital Plan which was being developed for the next three years would ensure that enabling schemes and other key projects were sequenced in a way which allowed the timeous implementation of the major, strategic capital projects.

- A re-examination of the original timetable submitted to the Scottish Executive Health Department of the proposed implementation plan for the totality of the Acute Services Strategy. The Chairman had asked that this be completed by the end of January 2003.

Director of Finance/ Chief Executive

(iii) Delivering the Targets for Waiting Times

The major waiting times standard which NHS Boards had to deliver on during 2003 was to reduce the maximum inpatient and day case treatment guarantee to a period of nine months. The Board had also agreed an interim target, to be achieved by end March 2003, of effecting a 50% reduction in the total numbers waiting beyond nine months, compared with the position at April 2002. The Board had received monthly reports on progress towards both the interim target and the December 2003 commitment. Preparatory work was in hand with the relevant NHS Trusts so that they were well positioned to meet these future waiting times standards.

Mr Divers referred to agenda item number 13 (Board Paper No 02/89, page 171 of the Board papers) entitled "Waiting Times", and noted the current waiting times position – as at November 2002; 853 Greater Glasgow NHS patients were awaiting over nine months.

Mr Divers highlighted the risk factors associated with meeting the waiting time targets including nurse staff shortages, infection outbreaks and changing doctors' working hours. Nonetheless, it was anticipated that the NHS Trusts were on target to meet the March 2003 interim commitment and also the December 2003 target. It was possible, however, taking into account the loss of elective capacity in recent months that the December 2002 position may see around 100 patients adrift from the original plan figure but that this should have returned to plan to achieve the March 2003 target.

ACTION BY

In response to a question from Dr Marshall, Mr Divers advised that he would illustrate the spread of delivery in relation to where treatments were being carried out (either via NHS Trusts or other private sector providers) and that this information would be included on the back of the digest produced monthly by the Board's Public Affairs Manager. Similarly, target figures would be shown on the monthly report.

Chief Executive

Director of Planning and Community Care

(iv) Maintaining Progress on Developing the Beatson Oncology Centre

The NHS Board received quarterly updates on progress in taking forward the action plan – first developed in December 2001. Four key strategic recommendations were summarized including:

- The appointment of a new Medical Director.
- Restoring the previous complement of Consultant Clinical Oncologists.
- Developing the Specialist Oncologist Service Plan for the West of Scotland.
- Developing the Business Case for the phase two redevelopment at Gartnavel General Hospital.

(v) Working to Reduce the Incidence of Health Care Acquired Infection

Mr Divers referred to the Circular HDL(2002)82 – a copy of which was attached to the NHS Board papers and set out the action required of NHS Boards and Trusts to address key recommendations arising from two reports namely:

- The Ministerial Action Plan on Health Care Acquired Infection.
- The Watt Group Report on the Outbreak of Salmonella Infection at the Victoria Infirmary.

A fuller report would be brought to the NHS Board early in 2003 when more opportunity had been given to consider the importance of these papers and their implications.

(vi) Developing the Staff Governance Agenda

NHS Greater Glasgow Staff Governance Committee had been established and had met twice. In addition, the Remuneration Subcommittee had now met for the first time. The Staff Governance Committee, the Area Partnership Forum and Local Partnership Forum were now considering the recently issued self-assessment audit tool, designed by the Scottish Partnership Forum to form the basis of assessing performance in delivering the staff governance standard.

Each Committee had distinct areas of work and responsibilities which were evolving. Two further priorities in the immediate work programme were to try to develop a more inclusive process which allowed a much broader range of staff to participate in the development of the update of the Local Health Plan and to complete the "mapping" exercise and review of the extant working groups' structures which should support the Forum's role.

ACTION BY

A number of priorities agreed at the conclusion of the Accountability Review meeting already featured in reports brought periodically to the NHS Board – that arrangement would continue. An updated composite report would be brought to the Board prior to the 2003 Accountability Review meeting.

DECIDED:

- That the mid year update of progress in taking forward the priorities agreed at the 2002 Accountability Review meeting with the Scottish Executive Health Department be noted.

- That a further update be provided to the NHS Board in the month preceding the 2003 Accountability Review meeting be agreed. **Chief Executive**

141. DRAFT LOCAL HEALTH PLAN UPDATE

A report of the Director of Planning and Community Care [Board Paper No 02/83] asked the NHS Board to discuss and endorse the draft Local Health Plan update for wider circulation and debate.

The Local Health Plan set a strategic direction for the next five years but focused in detail on 2002/03. This updated Plan retained a similar strategic direction but included more detailed plans and priorities for 2003/04 and an indication of progress in the past year. The content of the Plan was a product of a whole range of different planning processes which included Local Authorities, NHS staff and other stakeholders. Much of that detailed planning had also included significant public engagement. It was intended that the document would provide an overview and signposting to detailed plans. Furthermore, a summary for general readers would be produced.

Ms Renfrew highlighted a number of important issues for debate during this next phase of development including:

- Ensuring the GGNHSB-wide health improvement activity fully reflected and influenced local priorities.

- New policy issues and priorities where action needed to be finalised.

- The balance between focusing on the limited range of national priorities and our own local strategies and priorities.

- Our performance over the past year in delivering the commitments set out in the first Local Health Plan.

- Identifying areas and issues where further action was required to achieve our objectives.

- Developing a financial plan which ensured we delivered our objectives, including achieving financial balance.

Generating an early update would enable a substantial programme of work over the early part of 2003 to ensure the final version addressed the issues outlined and properly reflected detailed discussions with the Board's key partners.

ACTION BY

In response to a question from Professor Dickson, Ms Renfrew confirmed that risks would be identified and a section devoted to this in the final version. He also sought clarity on the reporting mechanisms for the key performance indicators which were improving health, reducing inequalities and improving health services. Furthermore, he sought a key performance indicator for Section 7.9 "Education and Training" as this was critical to NHS Greater Glasgow, both in terms of retention and development of the current workforce and in relation to ensuring the NHS Board was able to recruit trained and skilled staff. **Director of Planning and Community Care**

Mrs Kuenssberg was keen to give Section 7.6 "Workforce Planning" a higher profile given that it was one of the biggest challenges facing the NHS in Scotland and impacted greatly on not only health services but social care and other critical local authority services. Ms Renfrew accepted this point and explained that this particular section would be more action orientated in the final report. **Director of Planning and Community Care**

Mr Davison referred to the balance between providing too much or too little detail and directed the Board to page 53 of the Board papers, at paragraph 1.3 which highlighted the twelve national priorities to be:

- Health Improvement
- Delayed Discharge
- 48 Hour Access to Primary Care
- Mental Health
- Waiting Times
- Workforce Development and Staff Governance
- Cancer
- Heart Disease and Stroke
- Public Involvement
- Hospital Acquired Infection
- Financial Breakdown
- Service Design

The Board agreed with a point raised by Councillor Collins that the Local Health Plan information should target three distinct audiences, that being, the Scottish Executive, the NHS Board and its staff and patients and the public. Furthermore, the report should pick up on the effort being made to improve health, treat illness and care for the terminally ill – as such the report should be dovetailed demonstrating how these are tackled by NHS Greater Glasgow and how these significant resource priorities are structured.

Dr Nugent emphasised the importance in ensuring that the targets were not only top down but bottom up and a balance between local and national priorities.

Mr Goudie congratulated Ms Renfrew and her team for the vast amount of work carried out in preparing the draft Local Health Plan. **Director of Planning and Community Care**

Mr Cleland re-iterated the point of sustainability in that the Local Health Plan must reflect not only work being undertaken but that the Board aspires to – therefore, highlighting the competing priorities and that resources do not stretch to tackling everything.

Ms Renfrew agreed to capture the key themes arising from the debate and report these back to the Board with proposals for action. **Director of Planning and Community Care**

ACTION BY

DECIDED:

That the draft Local Health Plan update be endorsed for wider circulation and debate. **Director of Planning and Community Care**

142. IMPLEMENTING BEST PRACTICE IN CONSULTATION AND PUBLIC INVOLVEMENT : PROPOSED ACTION PLAN

A report of the Director of the Director of Corporate Communications, NHS Greater Glasgow [Board Paper No 02/84] was submitted asking the NHS Board to consider the proposed action plan on implementing best practice in consultation and public involvement and to determine if NHS Greater Glasgow should now proceed with implementation of the action plan as set out.

Mr McLaws summarized the beginning of pan NHS Greater Glasgow initiatives to modernize and build the infrastructure for public and patient involvement in the development and delivery of services. This approach allowed NHS Greater Glasgow to respond to the Scottish Executive's Patient Focus and Public Involvement guidance in a co-ordinated fashion. He invited Mr Whyteside to present the key points of the proposed action plan.

Mr Whyteside described the concept of the public involvement network for Greater Glasgow and the short-life action plan steering group, chaired by Brenda Townsend, Director of Nursing at Yorkhill NHS Trust. The action plan steering group maintained the position that even if the public involvement network had a strategic function, it must divide services, information and opportunities to frontline staff, public and patients that would ensure it performed a useful, valued and sustainable role.

The steering group proposed a phased action plan to begin the process of setting up the public involvement network. This first action plan was based on three clear strands:

- Establishment of a management committee for the public involvement network.
- Establishment of a database of people, involvement activity and expertise to underpin the network.
- Development of an over-arching NHS Greater Glasgow public involvement strategy.

There were staffing implications arising from these strands and the group proposed that staff should be designated/appointed in specific roles. It was stressed, however, that these proposed appointments were necessary only for the basic set-up and functioning of the network – development and delivery of the network and public involvement in general should be regarded as a mainstream function.

Councillor Collins welcomed the proposed action plan and asked that representation for the public involvement network management committee be sought from Greater Glasgow NHS Board's Women's Health Group. Similarly, Dr Hughes sought representation from the Area Clinical Forum (or Advisory Committee structure) on this management committee.

ACTION BY

Mr P Hamilton highlighted that the concept of successful public involvement took resources, time and investment. He welcomed this as the beginning of the improvement process and recognised that the detail had yet to be fleshed out prior to its delivery. He also asked the NHS Board to recognise that given Greater Glasgow's high deprivation, other means of communication with its public be sought outwith those of the internet and website.

Councillor McCafferty considered the report to be very encouraging with clear outcomes and broad vision. In response to a question regarding funding, Mr Whyteside confirmed that the management committee would be looking at this.

Mrs Smith saw this as an excellent opportunity to inform and involve Greater Glasgow's public. It was paramount to ensure audiences were sought in areas of social deprivation and recognise the influence within the business and faith communities.

Dr Nugent highlighted the two-way process as the public could also educate and shape NHS services as well as the NHS Board educating the public. As such, Mr Best highlighted the importance in being open and honest in the reporting back ensuring that the NHS Board was a listening organization.

Sir John summarized the discussion and thanked the Communications Team for the production of this report. It provided a practical approach in relation to priorities and partnership working. It set goals in an open and transparent way and he was reassured that time and effort would be taken to attract different audiences to encourage their engagement – this should include clinical colleagues.

DECIDED:

- That the proposed action plan on implementing best practice in consultation and public involvement be approved. **Director of Corporate Communications**

143. JOINT FUTURE IMPLEMENTATION INTEGRATED SERVICES : EAST DUNBARTONSHIRE COUNCIL AND NHS GLASGOW

A report of the Director of Planning and Community Care [Board Paper No 02/85] asked the NHS Board to endorse the proposal to integrate services with East Dunbartonshire Council for wide consultation.

Ms Renfrew detailed the thinking and development process which underpinned the proposals to:

- Develop an integrated structure for the provision of health and social care within East Dunbartonshire Council.

- Establish a formal joint committee as a vehicle for the establishment of a partnership structure.

The focus of these proposals was to improve services for people jointly cared for whilst, in parallel, recognizing a number of issues for staff. The proposals were a logical further step in the objective the NHS Board had been pursuing with Local Authorities bringing together staff and systems to improve services.

Councillor Duncan emphasised that the report had been approved for consultation by the Joint Planning Forum and Joint Trade Union Partnership Forum.

ACTION BY

Councillor Collins recognised the radical restructuring but was mindful of the NHS White Paper due to be issued in January/February 2003 which may have an impact on implementation and timescales – both processes should complement each other.

Dr Marshall sought further detail on the implications for the provision of health and social care and in particular, the choice people had, work currently being carried out within primary care, budget setting and the sharing of confidential information. Mr Reid was hopeful that the consultation process would encourage further discussion around these challenging elements.

DECIDED:

That the proposal to integrate services with East Dunbartonshire Council for consultation be endorsed. **Director of Planning and Community Care**

144. INFORMATION TECHNOLOGY AND COMMUNICATIONS (ICT) STRATEGY 2002-04 – PROGRESS

A report of the Director of Finance [Board Paper No 02/86] asked the NHS Board to note the progress made with implementing the ICT Strategy across NHS Greater Glasgow in the six months since its formal approval in May 2002.

Mrs Hull advised that significant progress had been made with each of the ICT priority projects, all of which were to timescale and budget. Importantly, strong working relationships had been established both with Information Technology (IT) staff across NHS Greater Glasgow and with the Scottish Care Information (SCI) Team. Pilot work had been jointly agreed that would take forward the creation of electronic records and an IT system to support the Ambulatory Care Hospitals. The NHS Greater Glasgow ICT Programme Board had been reconstituted to include all clinical chairs of IT Projects. This forum continued to lead with energy and enthusiasm the contribution that IT could make to modernizing patient services.

In response to a question from Dr Hughes, Mrs Hull confirmed that work was well underway to ensure ready home access to information for those professionals on-call.

DECIDED:

That the progress made with implementing the ICT Strategy across NHS Greater Glasgow in the six months since its formal approval in May 2002 be noted. **Director of Finance**

145. AIDS (CONTROL) ACT REPORT 2001/2002

A report of the Director of Public Health [Board Paper No 02/87] asked the NHS Board to approve the AIDS (Control) Act Report 2001/2002 report for submission to the Scottish Executive.

Dr Burns welcomed Dr Ahmed to present the findings within the report.

Dr Ahmed advised that for the first year heterosexuals had the highest number of cases of any group – 46% of the total new cases reported. There were 11 new cases of AIDS reported during the year and most of these were people who were unaware that they had HIV infection until they became seriously ill. There were five deaths during the reporting year which reflected the continuing success of the drug treatment known as highly active anti-retroviral therapy (HAART).

ACTION BY

The cost of HIV related treatment continued to rise and was likely to go on rising for the foreseeable future as the number of patients being treated was expected to continue to increase.

The main preventive measures continued to focus on reducing transmission between men who had sex with men and drug injectors.

DECIDED:

That the AIDS (Control) Act Report 2001/2002 be approved for submission to the Scottish Executive and be widely distributed by the NHS Board in accordance with the 1987 Act. **Director of Public Health**

146. QUARTERLY REPORT ON COMPLAINTS : JULY – SEPTEMBER 2002

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No 02/88] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow for the period 1 July to 30 September 2002.

The Head of Board Administration highlighted the performances of each Trust against the national target of 70% of written Local Resolution complaints to be completed within 20 working days of receipt. In response to a question from Mr P Hamilton, it was confirmed that the Board and all Trusts did acknowledge receipt of complaints within three working days.

Mr J Hamilton referred to the NHS Greater Glasgow draft procedure for Vexatious and Habitual Complaints which was currently out for consultation.

Members noted the action taken and lessons learned for patient care as a result of complaints within Greater Glasgow's four Trusts.

Mrs Smith highlighted the difficulty within the South Trust in meeting the timescales to consider requests for Independent Reviews particularly when there were limited Trustees available to deal with complaints. As such, an Associate Convener had been appointed.

DECIDED:

That the quarterly report on NHS Complaints in Greater Glasgow for the period 1 July to 30 September 2002 be noted.

147. 2002/03 FINANCIAL MONITORING REPORT FOR SEVEN MONTHS ENDED OCTOBER

A report of the Director of Finance [Board Paper No 02/90] asked the NHS Board to note the results reported for the first seven months ended 31 October 2002.

Mrs Hull explained that the overall forecast for the year-end remained break-even but there were issues emerging that would be more fully analysed in the Mid Year Review – due to be presented to the January 2003 meeting of the Board. She particularly noted the current level of spending on GP prescribing which had recurrent implications for 2003/4, although it remained that the in-year position could be offset by reserves. She acknowledged the commitment of Trusts to monitoring the overall balanced results through a series of individual and specific initiatives. **Director of Finance**

ACTION BY

DECIDED:

That the results reported for the first seven months ended 31 October 2002 be noted.

148. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 02/91] was submitted seeking approval of three medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Ishbel MacIver
Dr Jagdeep Luthra
Dr Pedro Larisma

Meeting ended at 12.20 pm

GGNHSB(M)03/2
Minutes: 13 - 26

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 18 February 2003 at 9.30 am**

P R E S E N T

Professor G C A Dickson (in the Chair)

Mr J Best	Mr W Goudie
Mr R Calderwood	Councillor J Handibode (to Minute 20)
Mr R Cleland (to Minute 20)	Mrs W Hull
Councillor D Collins	Mrs S Kuenssberg CBE
Ms R Crocket	Dr F Marshall
Mr T Davison	Mr I Reid
Mr T A Divers OBE	Mr A O Robertson OBE
Councillor R Duncan	Mrs E Smith

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

Ms E Borland	Acting Director of Health Promotion
Ms S Dean	Press Officer
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Planning and Community Care

B Y I N V I T A T I O N

Dr F Angell	Chair, Area Dental Committee
Dr A Bryson	Interim Director, Beatson Oncology Centre (to Minute 20)
Mr S Bryson	Representative, Area Pharmaceutical Committee (to Minute 21)
Mr P Hamilton	Convener, Greater Glasgow Health Council
Dr J Nugent	Chair, LHCC Professional Committee
Mr H Smith	Chair, Area Allied Health Professions Committee
Dr B West	Vice Chair, Area Medical Committee

ACTION BY

13. APOLOGIES

Apologies for absence were intimated on behalf of Professor Sir J Arbuthnott, Dr H Burns, Professor M Farthing, Councillor J Gray, Dr R Hughes, Councillor D McCafferty, Ms S Plummer (Nurse Adviser to Greater Glasgow NHS Board), Mrs C Anderson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Ms G Leslie (Vice Chair, Area Optometric Committee).

ACTION BY

14. CHAIRMAN'S REPORT

In the absence of the NHS Board Chairman, Professor Dickson updated on the following events in which the Chairman had been involved since the last NHS Board meeting:

(a) Trust Chairs and Chief Executives had been actively involved with the Chairman in compiling a programme for the all-day seminar (scheduled for 26 February 2003) on the possible implications of the White Paper for NHS Greater Glasgow.

(b) Following an interview of the Chairman with "The Herald", meetings had taken place with representatives from the Faulty of Medicine and the Faculty of Social Sciences, University of Glasgow to take forward the creation of a Glasgow Centre for Health Improvement. This project had gathered pace and the Chairman would progress it further with the Minister for Health and Community Care.

(c) The recruitment process for the selection of two NHS Board Members and one Trustee Member for the South Glasgow Trust had been completed. The selection panel's recommendation had been submitted to the Minister for Health and Community Care and it was expected he would make his final selection from the nominated candidates in mid March.

(d) Following visits from NHS24 to the NHS Board, the Chairman met with the NHS24 Board at its facilities in Clydebank and West Nile Street. A further meeting would be arranged to build a strong working relationship with NHS24.

(e) The Board Seminar held on 4 February had been devoted specifically to discussions about a possible strategy for NHS Greater Glasgow manpower requirements in the next ten years – running parallel with the Acute Services Strategy.

NOTED

15. CHIEF EXECUTIVE'S UPDATE

Mr Divers updated the NHS Board on the following issue:

In connection with the national agreement on low pay which had been concluded, a definitive letter from the Scottish Executive Health Department, Director of Human Resources was expected which would make it clear that the agreement was legally binding.

NOTED

16. MINUTES

On the motion of Mrs S Kuenssberg, seconded by Mr T Davison, the Minutes of the meeting of the NHS Board held on Tuesday 21 January 2003 [GGNHSB(M)03/1] were approved as an accurate record and signed by the Chairman.

ACTION BY

17. MATTERS ARISING

Members were circulated with the rolling action list which updated on the progress and timescale for ongoing matters arising.

NOTED

18. UPDATE ON IMPLEMENTING THE ACUTE SERVICES PLAN

Professor Dickson referred to the following three Board papers updating on implementing the Acute Services Plan:

6a – Acute Admissions Review : Initial Report
6b – Progress on Implementing the Strategy (including Communications Plan)
6c – Governance Aspects

Each was taken in turn.

18a Acute Admissions Review : Initial Report

A report of the Director of Planning and Community Care [Board Paper No 03/9a] asked the Board to note and consider emerging issues to-date on the initial programme of acute admissions review work in the context of an overview of progress on implementing the Acute Services Review.

Ms Renfrew described the structure of the review process and, in particular, the three groups in place to deliver the required outcomes. She highlighted the functions, membership and remit of the three groups namely:

- Review Steering Group
- Review Project Group
- Trust Implementation Groups

The first phase of the review had focused on developing a clear diagnosis of the issues to be addressed – this phase had had a number of elements including:

- SECTA's Report, contracted to provide external, expert support – their report was based on a programme of visits to each hospital site, interviews with key staff, analysis of data provided by Trusts and SECTA's experience from work elsewhere. A detailed report would be finalised and circulated as SECTA continued to provide support to the project group.

- Staff Open Sessions – sessions, open to all frontline staff in each hospital, were undertaken to hear staff views.

- Workshops – two workshops had taken place, organised by SECTA and the project group, bringing together a broad range of clinical and managerial staff.

- Website – The review had a dedicated page of the GGNHSB website – including all relevant papers and reports and with a facility to email in comments and suggestions.

All of the activity outlined above had enabled the acute admissions review to arrive at a degree of clarity on the key components of the problem.

ACTION BY

Ms Renfrew summarised the conclusions from the diagnostic activity which were linked to four key areas:

(i) The assessment and entry of patients into Greater Glasgow's hospitals.

(ii) The processes for transferring patients within each of the hospitals.

(iii) Blocked/closed beds and staffing levels.

(iv) Discharge processes.

Based on the problem diagnosis, the project group had drafted a detailed project plan which identified a series of strands of work which Ms Renfrew summarized as follows:

A. Assessment and Admission

B. Patient Discharge

C. Clinical Support Services

D. Workforce

E. Care Pathways

F. Community Services

G. Key Client Groups (older people, homeless people, people with addictions, head injuries and palliative care)

H. Infrastructure

This work programme would also be informed by clinical advice and a programme of visits to other UK services which was already underway.

The next phase of the review process would involve working with Trusts to identify and address any other short-term issues which could improve their current position. From the progress the review had already made, however, it was clear that many of the issues were not amenable to quick solutions but were likely to require significant systematic change such as shifting patterns of clinical support services, the organisation of Consultant time and physical facilities.

Furthermore, the modern system of care which was already emerging from the review process would require a higher level and different organisation of clinical resources. As such, it would be necessary to make an in-depth assessment of whether such a system was achievable and sustainable in terms of workforce and resource on the current five sites.

Mr Calderwood re-iterated the point of looking at current systems in terms of physical and resource planning but also the importance in testing the hypothesis of managing acute services on three sites which was the ultimate goal.

ACTION BY

Councillor Collins looked forward to seeing the finalised report of the Acute Admissions Review particularly the aspects of the policy groups which involved joint planning and working with the Board's Local Authority partners.

In a response to a question from Dr Nugent, Ms Renfrew confirmed that the delayed discharge figures changed month by month in accordance with nursing home capacity. Throughout the city, at the moment, there were different lengths of Consultant receiving duties with most only on a 24 hour commitment. Such arrangements potentially disrupted continuity of care and created unscheduled ward rounds. This system of management of clinical episode and acute admissions could be improved.

Mr Cleland referred to current issues and pressures which were very relevant in assessing a re-allocation of priorities and determining any room for manoeuvre. Mr Divers confirmed that a balance would be struck between a strategic piece of work and looking at next year's Local Health Plan choices and service pressures. A need for short-term action had to be seen in light of the overall financial position given that the Acute Services Strategy was in its implementation phase.

Ms Renfrew referred to the new money available to address the pressure of delayed discharge but identified that the challenge lay in changing people's working patterns not solely on resource issues. The project team had looked at the handling of delayed discharges in Leeds and Sheffield and their views on this would be included in their final report.

Mrs Kuenssberg emphasised that the review should not be restricted to acute admissions but relate widely to all Greater Glasgow hospitals recognising that these issues should be addressed regardless of the review. In response to a question from Mrs Kuenssberg regarding patient involvement, Ms Renfrew confirmed that Greater Glasgow Health Council were involved in the steering group and discussion had taken place with patients at the diagnostic stages. She accepted, however, that this was a further area of work that could be expanded.

Director of Planning and Community Care

DECIDED:

That the initial report on the Acute Admissions Review (and its emerging issues) be noted.

18b. Progress on Implementing the Strategy (Including Communications Plan)

A report of the Chief Executive [Board Paper No 03/9b] asked the Board to receive the progress report on taking forward the early stages in implementing the Acute Services Plan and to approve the next steps in the detailed Communications Plan.

The key early implementation steps had been two-fold: firstly, to ensure timely progress in moving forward the approved mechanisms and ensuring procurement launches for the first three capital projects (namely, the two ambulatory care hospitals and Phase 2 of the Beatson Oncology Centre); and secondly, to put in place overall project management structures which would allow work to progress on the key planks of implementation and review.

ACTION BY

Mr Divers summarised these key issues in turn:

(i) Moving to Procurement of the Two Ambulatory Care Hospitals and Phase 2 of the Beatson Oncology Centre

The business case in respect of the two ambulatory care hospitals which would be developed at the Victoria Infirmary and Stobhill sites was approved by the Scottish Executive Health Department and the aim was now to proceed to procurement advertisement by the end of February.

Steady progress was continuing with the plans for the Phase 2 re-development of the Beatson Oncology Centre for which the Minister had already pledged Treasury funding.

Bevan Ashford and Shepherd Wedderburn had been appointed as the Board's legal advisers in taking forward the plans for the early years of implementation. The arrangements for the appointment of financial advisers were in hand with shortlisting interviews taking place in late February. It would then remain to appoint technical advisers to work as part of the NHS Board's Project Team in taking forward this major procurement programme.

(ii) Project Management

The philosophy behind this major programme of procurement was that the approach would mirror the arrangements for unified working within NHS Greater Glasgow. The implementation plan would be led by a Project Director at Executive Director level which would ensure that there was a clear Executive end point for concluding any cross organisational debates. The Project Executive Group (set up to oversee implementation activity) had established structural subgroups for whom lead Executive Officers had been agreed. The subgroups were as follows:

- Capital Planning and Procurement
- Financial Planning
- Communication and Community Engagement
- Transport and Accessibility
- Services/Beds/Activity

There was also being established a broader based subgroup addressing workforce planning. Each of these subgroups was preparing a set of terms of reference and membership arrangements so that the subgroups could be created within the next few weeks.

Mr Divers invited Mr McLaws to update on the Communications Action Plan.

Mr McLaws confirmed that NHS Greater Glasgow Communications staff had progressed on a highly pro-active mass communication plan to reach out to staff and communities. Strategies had been put in place to engage more effectively with the media, local communities, and the pan Glasgow audience and work in closer partnership with Local Authorities to enhance effective communication.

ACTION BY

He summarised the three main communication vehicles that would be used in Phase 1 of the action plan:

1. NHS Greater Glasgow News – this would be in the form of a sixteen page full colour high quality newspaper. 150,000 copies would be distributed to around 1,000 sites (including NHS Greater Glasgow's FHS practitioners, libraries, hospital sites, major supermarkets, various shopping centres and Local Authority headquarters). The target audience was staff, patients and the general public. Mr McLaws described the content on the sixteen page newspaper as providing a focus on what the new hospitals within NHS Greater Glasgow would look like and would provide.

2. NHS Greater Glasgow Website – the launch of this would coincide with the first edition of NHS Greater Glasgow News. The content of the website would feature:

    - Acute Hospital Modernisation Programme
    - Interactive News Site
    - Public Involvement
    - Stop Smoking
    - Over Web Site Links
    - Proactive Media Activity

3. Modernising Acute Hospitals Information Packs – both the web site and the newspaper will invite people to request information folders giving details of the hospitals they wished to learn about. Each pack would contain a detailed 9 page overview of the process to date complete with images and editorial detailing sequence of events, rationale behind the acute strategy and investments to be made.

Mr McLaws went on to describe briefly Phase 2 and 3 of the Communications Action Plan which would evolve from the needs, demands and aspirations driven from Phase 1.

Councillor Collins complimented the Communications Team in taking forward this agenda so quickly. He encouraged all Local Authority areas to be actively involved particularly recognizing that different Local Authority areas had different systems of communication in place. Mr McLaws confirmed that the launch of the newspaper and web site would take place the same day throughout all of NHS Greater Glasgow and this included all Local Authority headquarters. He envisaged future shared information and links with Local Authority newspapers and web sites.

In response to a question from Dr Angell, Mr McLaws confirmed that the Communications Team was looking at the availability of the newspaper in Braille and other community languages. Following on from that point, Mr P Hamilton encouraged Mr McLaws not only to rely on access of information via the internet. Mr McLaws confirmed that the information would be available on CD Rom versions which could be made available and presented within communities to ensure a consistency of the message.

Mrs Smith commended the considerable achievement made and encouraged particular engagement within the social exclusion areas and volunteer groups.

Professor Dickson asked that all Board Members receive multiple copies of the newspaper for their own personal distribution and use. **Director of Corporate Communications**

ACTION BY

DECIDED:

(i) That the progress report on taking forward the early stages in implementing the Acute Services Plan be received and noted.

(ii) That the next steps in the detailed Communications Plan be approved. **Director of Corporate Communication**

18c Governance Aspects

A report of the Chief Executive [Board Paper No 03/9c] set out the suggested governance role for the NHS Board during the implementation of the Acute Services Plan and asked whether the arrangements proposed required further strengthening.

Mr Divers set out the three main elements of the Board's governance responsibilities as the Acute Services Plan moved to the implementation stage:

1. Being Assured that a Credible Implementation Plan was in Place – over the coming weeks, the project team would be developing a detailed project plan for the implementation of the entire Acute Services Strategy. That plan would set out the key milestones in implementation and would highlight specifically the critical points at which the NHS Board's governance role will be discharged.

2. Taking Key Decisions about the Procurement Strategy, Consistent with Affordability – In addition to its overview of the project management and implementation arrangements, the NHS Board would be involved directly in taking key decisions about the procurement of the new hospital facilities. Accordingly, the NHS Board would be asked to approve the approach to the procurement on which the legal and financial advisers would guide the project team. Such decisions would be set in the context of the overview of affordability which would underpin the implementation of the plan. That overview of affordability would itself regularly be updated at NHS Board meetings as part of the ongoing governance arrangements.

3. Being Assured that the Project Management Arrangements Would Meet the Requirements for External Review and Monitoring Which the Minister had Agreed – the NHS Board would require to be assured, through the medium of the quarterly update, that adequate arrangements were in place to meet the terms of reference set down for Audit Scotland's involvement. Furthermore, the Board would wish to be assured that appropriate arrangements were put in place to support the work of the two monitoring groups (set up to look at the continuation of named services within Stobhill Hospital and the Victoria Infirmary).

Mrs Kuenssberg found the suggested governance roles for the NHS Board very helpful and suggested the following addition:

"The NHS Board requires to be assured that a detailed implementation plan for this major project is developed and implemented, *progressing to time and on budget*".

This would ensure that regular updates were reported to the Board and milestones achieved. **Chief Executive**

ACTION BY

In response to a question from a Member, Mr Divers confirmed that the overall Project Director would report to himself and would be a regular attender at future Board meetings.

Mrs Smith commended the robust system of governance, leadership and accountability which would ensure the Board undertook what it had been tasked to do by the Minister for Health and Community Care.

Mr Goudie sought inclusion of the partnership approach but was assured that although the paper only highlighted the high level governance aspects; partnership was fully representative and integral at an operational level.

Mr Cleland referred to the Executive level input to the various subgroups set up to look at aspects of implementing the Acute Services Strategy. He asked about the contribution non Executives could make further improving the governance role of the NHS Board. The non Executive Members were supportive of this suggestion and agreed that their contribution would enrich the work of any project group or external process. Mr Divers agreed to make clear the accountability arrangements for such arrangements in relation to the project groups recognising that it would not alter the overall system of governance. To this end, this issue could be further discussed at the forthcoming Board Member away-day. **Chief Executive**

DECIDED:

- That the discussion paper setting out the suggested governance role for the NHS Board during the implementation of the Acute Services Plan be received and noted.

- That the above comments suggested which would further strengthen the arrangements be included. **Chief Executive**

- That a copy of the paper be sent to Audit Scotland. **Chief Executive**

19. BEATSON ONCOLOGY CENTRE – UPDATE OF ACTION PLAN

A report of the Chief Executive and Interim Director, Beatson Oncology Centre [Board Paper No 03/10] asked the Board to receive the update of progress in implementing the action plan and authorise production of a further update to the Board in June 2003.

Mr Divers updated on the key action points set out in the report made by the Expert Advisory Group, whose initial report was considered by the NHS Board one year ago.

He summarised progress on those key issues within the action plan which the NHS Board had recognised as crucial in its previous discussions.

These included the appointment of a Medical Director (Professor Alan Rodger who would take up post on 2 June 2003). In terms of the overall staffing position within the Centre, the significant pressure remained on Consultant Clinical Oncologists, with no further substantive appointments made since last summer, in spite of on-going recruitment efforts. As such, Professor Rodger would be turning his attention to a recruitment strategy. Nonetheless, at end January 2003, there were 72 WTE more staff in post than at end March 2002.

ACTION BY

Discussions had taken place to further develop a detailed West of Scotland Plan for Specialist Oncology Services. Those discussions had led to broad agreement in four of the five areas about the future pattern and disposition of specialist oncology services within each West of Scotland area. That work would now progress to allow the first stages in implementing this West of Scotland plan to be taken forward early in the new financial year.

The submission of the Phase 2 Business Case to the Scottish Executive Health Department's Capital Investment Group had been made and it was expected that the project would be able to proceed to procurement during March 2003.

Dr Bryson emphasised the ongoing difficulty regarding recruiting Consultant Clinical Oncologists but was reassured that the Beatson Oncology Centre had seven more Consultants present than Spring last year (which was two more than in November 2001). Although staff were still working under pressure, recruitment was ongoing particularly in terms of efforts being made to recruit to posts with defined specialist responsibilities in particular tumour types. An example of this was the current Consultant post being advertised with a major interest in the management of lung cancer.

In terms of further changes in the ways of working, a chemotherapy facility had been developed at Gartnavel General Hospital which had seen 70% of activity being transferred to that facility in an effort to alleviate congestion within the Beatson Oncology Centre. In connection with this, Mr P Hamilton commended Ward 4C at Gartnavel General as being a first class facility.

Professor Dickson recorded his gratitude to Dr Bryson for the role he had discharged since his secondment to the Beatson Oncology Centre.

DECIDED:

- That the update of progress in implementing the Action Plan be noted.

- That a further update of the Action Plan be included on the NHS Board agenda in June 2003. **Chief Executive**

20. TOBACCO STRATEGY

A report of the Acting Director of Health Promotion [Board Paper No 03/11] asked Members to approve the draft Tobacco Strategy for Glasgow and commit NHS Greater Glasgow to contributing to the strategy's implementation.

Mrs Borland highlighted that smoking was the biggest single preventable cause of premature death in Greater Glasgow (with over 2,500 deaths annually directly attributable to smoking). While the health improvement performance targets for smoking were challenging for Scotland, they were even more so for Greater Glasgow.

The draft Tobacco Strategy, issued for consultation by the Glasgow Alliance, set out a co-ordinated multi-agency approach to tackling smoking. Mrs Borland highlighted the strategy's aims and objectives and summary of current activity including:

- Co-ordinating work on tackling tobacco in NHS Greater Glasgow
- Developing healthy policy and raising public awareness
- Working with young people
- Smoking cessation support

ACTION BY

Continued, sustained and co-ordinated action was required to reduce the impact of tobacco on Greater Glasgow. The development and implementation of Glasgow's Tobacco Strategy was, therefore, vital to improving the health of the city.

Mr Goudie suggested that the draft Strategy be endorsed subject to the statement "to make smoke free public places the norm and to work towards a situation where all employees are protected from environmental tobacco smoke" strengthened. Mr Calderwood commented that this had to be seen in light of the Board's original policy which facilitated patients to express a choice.

Dr West referred to the Pharmacy Research Project in North Glasgow Trust piloting a smoking cessation service for acute patients, linking with the community pharmacy service. She would welcome such a similar project in the South Trust although recognised that the bulk of smoking cessation services took place within the community but more could be targeted at acute level.

Mr Bryson commended the strength of model in community pharmacists delivering pharmacy smoking cessation support services. Their success was due to a balance between locally based, no appointment necessary and ease of access. As pharmacists had been empowered to dispense nicotine replacement therapy (NRT) a 30% client return rate to the pharmacists was currently achieved which demonstrated an excellent percentage.

Given the range of views received on the draft Strategy, Professor Dickson encouraged all Board Members to submit their comments in writing should they wish.

DECIDED:

- That the draft Tobacco Strategy for Glasgow be approved. **Acting Director of Health Promotion**

- That NHS Greater Glasgow be committed to contributing to the Strategy's implementation. **Acting Director of Health Promotion**

21. FINANCIAL PROSPECTS FOR 2003/2004

A report of the Director of Finance [Board Paper No 03/12] outlined details of the 2003/04 Revenue Allocations to NHS Greater Glasgow.

Mrs Hull described the overall growth monies of 7.4% received by NHS Greater Glasgow, equating to £66.7M new funds. This sum was considerably above the anticipated cost of inflation and pay awards and would provide investment opportunities to modernise and improve services to patients, in line with national priorities.

The declining population identified in the 2001 Census, combined with the recognised levels of ill health, did present the NHS Board with significant challenges in setting a balanced budget in 2003/04.

From the new monies available, adequate provision would need to be made for pay costs and related baseline requirements. Thereafter, the Board would need to decide how best to commit remaining funds to ensure national targets and priorities were met. All of this was against a backdrop of continuing the need to ensure that the Acute Services Implementation could be afforded as new developments came on stream. This would be discussed at the Board Seminar on 4 March 2003.

ACTION BY

DECIDED:

- That the report be noted.

- That a more detailed analysis of the implications for investment and budget decisions in 2003/04 would be presented at a later meeting. **Director of Finance**

22. REVIEW OF PURCHASED ADDICTION SERVICES

A report of the Director of Planning and Community Care [Board Paper No 03/13] asked the Board to note the initial findings of the Review of Purchased Addiction Services and approve early discussions with the service providers on the initial findings of the review.

Glasgow City Council established a review of purchased addiction services in November 2001. The review process was established on a joint basis covering services purchased from the NHS in addition to the Local Authority. The review was directed by an inter-agency steering group which included Primary Care Trust input as well as significant involvement of the GGNHSB Addiction Planning Team.

The review was established as one of the final elements of a comprehensive joint consideration of all drug and alcohol services. The key objectives of the review were to:

- construct and implement a purchasing strategy informed by needs indicators, effective research and a financial framework

- produce quantitative and qualitative information on current services.

Ms Renfrew set out the analysis of need and which services should be commissioned to address these needs. She described the conclusions of the review of what services and interventions were effective, described progress so far on this joint review and the process to begin a dialogue with service providers to inform definitive conclusions.

In response to a question from Councillor Collins, Ms Renfrew confirmed that a process was underway to roll out such a review in the other Local Authority areas – this was being led by Glasgow City Council.

DECIDED:

- That the initial findings of the Review of Purchased Addiction Services be noted. **Director of Planning & Community Care**

- That early discussions with service providers on the initial findings of the Review be approved. **Director of Planning & Community Care**

23. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/14] noted progress towards delivering the Board's agreed over nine month waiting time reduction.

ACTION BY

Ms Renfrew referred to the factors affecting the March 2003 position in both North and South Glasgow Trusts. These risks were highlighted to the Minister in October 2002 and in the Waiting Times and Standards 2002/03 paper submitted to the September 2002 Board which laid out GGNHSB's submission to the National Waiting Times Unit and described how it aimed to achieve the accountability review target to reduce the numbers of over 9 month waiters (with guarantees) by 50% by March 2003. In figurative terms this related to 325 patients (the January 2003 provisional figure being 853 patients).

Ms Renfrew referred to the additional information provided relating to those patients waiting over 9 months with no guarantee and also those patients who were being treated within guarantee targets. The figures demonstrated that overall, NHS Greater Glasgow was successful in ensuring that the large majority of patients received their treatment within the 9 month guarantee period.

The First Minister announced on 11 February that the current target of 26 weeks for an outpatient consultation would be accelerated by one year to 2005 and that a more accurate system of recording and monitoring the number of people waiting for an outpatient appointment would be introduced. He also announced that within coronary heart disease from 2004, there would be a guarantee that patients would not wait more than 18 weeks from diagnosis to treatment.

NOTED

24. 2002/03 FINANCIAL MONITORING REPORT FOR NINE MONTHS ENDED DECEMBER

A report of the Director of Finance [Board Paper No 03/15] asked the Board to note the results reported for the nine months ended 31 December 2002.

Mrs Hull confirmed that Greater Glasgow's Trusts were reporting a £2.165M deficit against the break-even target for the nine months to December 2002. This was a slight improvement of £370K on the November 2002 position. Overall, therefore, the position remained in line with that forecast. It was still anticipated that the total estimated £2M overspend against Trusts' startpoint allocations could be offset by reserves available at the year end.

NOTED

25. MINUTES OF GREATER GLASGOW HEALTH AND CLINICAL GOVERNANCE COMMITTEE

The Minutes of a meeting of the Greater Glasgow Health and Clinical Governance Committee [GGNHSB(HCGC)(M)03/1] held on Tuesday 28 January 2003 were noted.

ACTION BY

26. ANY OTHER BUSINESS

(i) Professor G C A Dickson and Dr F Marshall

Mr Robertson referred to the fact that this was the last meeting of the NHS Board for Professor Dickson and Dr Marshall. On behalf of the NHS Board he acknowledged their huge contribution to the Board particularly in relation to their understanding of the vast range of health related issues. Their deep knowledge and careful attention to detail had been greatly valued and appreciated throughout their terms of office. Similarly, they had both been pro-actively involved in various subcommittees and working groups of the NHS Board where their experience and commitment had been gratefully appreciated. The NHS Board had valued their forthright and refreshing interpretation of many of the issues they had embraced as Members.

Professor Dickson and Dr Marshall thanked Mr Robertson and all Board Members for their kind sentiments and wished the NHS Board well for the challenges that lay ahead.

The meeting ended at 11.45 am

GGNHSB(M)03/3
Minutes: 27 - 42

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 18 March 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Best	Mr W Goudie
Dr H Burns	Councillor J Gray (to Minute 36)
Mr R Calderwood	Councillor J Handibode (to Minute 36)
Mr R Cleland	Mrs W Hull
Ms R Crocket	Mrs S Kuenssberg CBE
Mr T Davison	Councillor D McCafferty
Mr T A Divers OBE	Mr I Reid
Professor M Farthing	Mr A O Robertson OBE (to Minute 33)
Mrs E Smith	

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

Ms E Borland	Acting Director of Health Promotion
Ms S Dean	Press Officer
Ms S Fitzgerald	Legal Adviser – Bevin Ashford and Shepherd Wedderburn (from Minute 34 to 35)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Dr J McMenamin	Consultant in Public Health Medicine (from Minute 35 to 36)
Ms D Nelson	Communications Manager
Ms C Renfrew	Director of Planning and Community Care
Mr J Whyteside	Public Affairs Manager

B Y I N V I T A T I O N

Mrs C Anderson	Chair, Area Pharmaceutical Committee (to Minute 36)
Dr F Angell	Chair, Area Dental Committee
Mr J Cassidy	Chair, Area Nursing and Midwifery Committee
Mr P Hamilton	Convener, Greater Glasgow Health Council
Dr J Nugent	Chair, LHCC Professional Committee

ACTION BY

27. APOLOGIES

Apologies for absence were intimated on behalf of Councillor D Collins, Councillor R Duncan, Dr R Hughes and Ms G Leslie (Vice Chair, Area Optometric Committee).

ACTION BY

28. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

(a) Scotland's Health White Paper "Partnership for Care" had been issued. Further detail on the content of the White Paper would be provided by Mr Divers at Paper No 03/16.

(b) The new proposed GP contract had been announced and included a template which would enable practices to estimate their income. The consultation of the contract within NHS Greater Glasgow was being led by the Primary Care Trust.

(c) A new policy paper had been introduced on Monday 17 March 2003 entitled "Improving Health – the Challenge". This made clear what the health improvement aims within NHS Scotland should be.

(d) 120,000 copies of the NHS Greater Glasgow Health News Newspaper had been distributed. Furthermore, the new website had generated activity with a particularly impressive increase in the uptake of the Smoking Cessation Scheme.

(e) The Minister for Health and Community Care would announce shortly the North and South Monitoring Groups to take forward the monitoring of the continuation of "named services" within Stobhill Hospital and the Victoria Infirmary, during the period prior to the rationalisation of inpatient services.

(f) Two new Board Members had been appointed by the Minister for Health and Community Care; Peter Hamilton and Ravinder Kaur Nijjar. The Chairman congratulated both and looked forward to working with them as Non Executives from the 1 April 2003. A new Trustee had also been appointed to South Glasgow University Hospitals NHS Trust, Mrs Maire Whitehead.

Councillor D McCafferty had intimated his resignation from the NHS Board as it was his intention to stand as a Parliamentary candidate in the forthcoming elections. The Chairman thanked Councillor McCafferty for his contribution to the work of the NHS Board since his appointment on 1 October 2001. It was also the last meeting of Dr R Hughes (as his Term of Office as Chairman of the Area Clinical Forum expired on 31 March 2003) and Sir John thanked him for his input which had been greatly valued.

NOTED

29. CHIEF EXECUTIVE'S UPDATE

Mr Divers updated the NHS Board on the arrangements for the North and South Monitoring Groups to be set up by the Minister for Health and Community Care. The first meeting of these Groups would take place on 28 March at which Members would discuss and agree their remit. It had been proposed that each Group meet three times a year, with the Chair of both Groups holding monthly meetings with the NHS Board Chairman

NOTED

ACTION BY

30. MINUTES

On the motion of Mr J Best, seconded by Mrs E Smith, the Minutes of the meeting of the NHS Board held on Tuesday 18 February 2003 [GGNHSB(M)03/2] were approved as an accurate record and signed by the Chairman.

31. MATTERS ARISING

Members were circulated with the rolling action list which updated on the progress and timescale for ongoing matters arising.

NOTED

32. PARTNERSHIP FOR CARE : SCOTLAND'S HEALTH WHITE PAPER

A report of the Chief Executive, GGNHSB [Board Paper No 03/16] asked the Board to receive the report on the Health Department's Guidance on implementing the Health White Paper - Partnership for Care and discuss the next steps in taking forward the plans for implementation.

The main themes of the White Paper were:

- The challenge of health improvement.
- The importance of listening to patients.
- The delivery of consistent, safe, high quality care, supported by national standards and robust inspection arrangements.
- A significant emphasis on clinical reform and service redesign.
- The continuing emphasis on partnership working with staff and the need to equip staff with the tools and skills necessary to deliver high quality care.
- Arrangements for strengthening unified NHS Board working through a move to single NHS organisations, with clear lines of accountability.

Mr Divers aimed to focus on the key elements within the Guidance [NHS HDL(2003) 11] and on the processes of implementation which the NHS Board was charged with taking forward. The main areas for consideration were as follows:

- Moving to unitary NHS organisations.
- Devolution of powers; schemes of delegation from NHS Boards to and within operating divisions.
- A repositioning of NHS Scotland Management.
- The role of NHS Chief Executives in single system working.
- Changes to membership of NHS Boards.
- The Development of Operational Divisional Management Teams.

ACTION BY

- The legal steps to Trust dissolution.

Mr Divers covered each in more detail:

(i) Moving to Unitary NHS Organisations

NHS Boards which operated with NHS Trusts were required to bring forward simple, practical proposals as soon as possible, but no later than April 2004, to enable the Trusts in their areas to be dissolved, with the Trusts' functions, staff and assets transferring intact to new Operating Divisions of the NHS Board. This evolutionary approach was designed to allow NHS leaders to concentrate on supporting improvements in patient care in order to take forward the key national priorities which were set out in the White Paper. The Guidance made it clear that the dissolution of Trusts would have no substantive impact on the employment of staff, since employers' obligations were transferred directly to the respective NHS Board.

Given that the timescale had been set at no later than April 2004, it was possible that Ministers would wish to see the single system working arrangements in place by April 2004. That timescale would require launch of the public consultation paper in August 2003 with decisions by the NHS Board by December 2003.

Mrs Smith recognised the role of existing NHS Trust Chairs being vital to ensure a seamless transfer but sought recognition of the high profile Chief Executives role in the four Glasgow NHS Trusts. For them to be proactively involved in the unitary NHS organisation, organised formal support would have to be provided at their respective Trusts should they be engaged elsewhere.

Councillor McCafferty sought clarification of the future of the Golden Jubilee Hospital delivering waiting time guarantees ensuring best use to maximise effect to delivery of local NHS plans. Given the plans for decentralisation, it was his view that the Golden Jubilee Hospital should be decentralized and not held under the ownership of the Scottish Executive.

Mrs Kuenssberg was re-assured that the transfer of NHS Trust employees would be straight forward in that staff would return to a single employer – that of Greater Glasgow NHS Board although there was an issue of harmonization of human resources policies.

In terms of the plans for development of the Community Health Partnership arrangements, Dr Nugent welcomed the less prescriptive but more flexible arrangements.

In summary, Sir John highlighted the following key areas which would be further discussed at a Board seminar:

- Ensuring support was available for existing Trusts particularly in the transitional arrangements.

- How would the Golden Jubilee Hospital fit into a devolved structure?

- Preparation for the Community Health Partnership arrangements.

- Ensuring the human resource management issues of harmonization did not throw up unexpected difficulties.

ACTION BY

(ii) Devolution of Powers: Schemes of Delegation from NHS Boards To and Within Operating Divisions

A new duty on NHS Boards was introduced putting in place devolved systems of decision making. On the dissolution of NHS Trusts, NHS Boards would devolve duties and responsibilities for service delivery to new Operating Divisions. This would be achieved by converting the current Trust Management Teams into Committees of the NHS Board to be known as Divisional Management Teams.

The devolution of powers direct from NHS Boards to Operating Divisions was intended to ensure that Divisional Management Teams were as flexible as the current Trust Management Teams. These new arrangements were intended to ensure that NHS Boards preserved their status as strategic Boards of governance and that they were not unnecessarily drawn in to day-to-day management issues.

There was flexibility for NHS Boards to consider developing arrangements in ways that were different from the suggested model, provided that there was agreement achieved locally on this and that benefits of the different arrangements proposed could be demonstrated. It was crucial, however, that an appropriate balance should be maintained between the need to avoid the disruption frequently associated with organisational change and the over-riding aim of securing tangible benefits for patients.

In summary, the NHS Board needed to determine whether the expected pattern of migration to Divisional Management Teams would deliver the priorities within the White Paper. Formal Schemes of delegation needed to be prepared both between NHS Boards and Operating Divisions and within Operating Divisions. These were likely to be required to form part of the consultation paper.

Councillor McCafferty raised the issue of elected representatives being Members of Divisional Management Teams. Mr Divers confirmed that this was not the model described in the Guidance but that a Non Executive Director of the NHS Board carried the responsibility of Chair of the Management Team.

(iii) A Repositioning of NHS Scotland Management

The White Paper aimed to bring about a material repositioning of NHS Scotland management to reflect its critical importance in working with clinicians to enable service change and clinical reform. Working within unified NHS systems, Divisional Chief Executives would have key cross-system leadership roles in the drive to integrate, redesign and develop patient centred services. NHS Boards must ensure that all Chief Executives carried appropriate cross-system, regional or national leadership roles in terms of:

- a new duty of regional (and national) planning
- support for clinical leadership

Chief Executives and other senior members of the Executive Teams were already taking leadership roles across the local NHS system, in respect of the roll out of the acute services plan and other key areas, including workforce planning. Further rigour needed to be built in to the "rules of engagement" on regional planning, however, to avoid some of the current impediments to progress. There was an urgent need to put in place the Service Redesign Committee if it was to play a material role in the first Change and Innovation Plan.

ACTION BY

Professor Farthing regarded this as an exceptionally important component of the White Paper particularly as there had been a dislocation in the relationships between some clinical groups and some managers. It was paramount to have a pro-active plan to address this and revolutionary ideas to engage all key players.

Mr Goudie sought the representation of staff organisations on the Service Redesign Committee.

Mrs Kuennsberg was keen that discussion took place with patients on how they may be consulted in the future. She was also disappointed to note that no financial arrangements had been set for regional planning.

Ms Crocket saw the importance of ensuring medical colleagues were on board but re-emphasised the need for a multi-disciplinary approach ensuring the whole NHS Greater Glasgow workforce was involved in driving the plans forward.

Professor Farthing re-iterated Ms Crocket's view and suggested one approach may be to plan peoples' careers better across the clinical spectrum.

(iv) The Role of NHS Chief Executives in Single System Working

The role of NHS Board Chief Executives would be broadly unchanged – the major difference was that, instead of discharging responsibility for implementation through separate statutory bodies, the responsibility would be discharged through Operating Divisions of the NHS Board. Similarly, the roles of Divisional Chief Executives would match closely the current roles of Trust Chief Executives in that they would continue to be accountable for their budget, the performance of their organisation and leading the work of the Divisional Management Team.

Two changes flowed from the move to single NHS organisations. Firstly, Divisional Chief Executives would not be appointed formally as accountable officers, but they would still have primary accountability for their budgets and would still be liable to be summonsed to give evidence to the Parliament. Secondly, the Chief Executive of the NHS Board would have overall accountability for the performance management of the whole NHS system and there would, therefore, be a direct line of accountability from Divisional Chief Executives to the NHS Board Chief Executive.

These formal changes would not, however, affect the status, authority or autonomy of Divisional Chief Executives. Other members of the former Trust Executive Teams would fulfill the same roles as before but as part of the Divisional Executive Team.

All the Chief Executives in the NHS Board area must operate in a strong, unified team providing leadership in agreed areas across the local NHS system, with specific operational results being delivered by Divisional Chief Executives and their Executive Teams. The NHS Board Chief Executive would be responsible for performance assessment of Divisional Chief Executives in consultation with the Chair of the Divisional Management Team.

In summary, Mr Divers commented that the relationship between Chief Executives should further be formalised by the early establishment of a Board level Executive Team and that the Board's Remuneration Subcommittee was already aiming to move substantially for the performance year 2003/2004 towards the arrangements set out in the guidance.

ACTION BY

(v) Changes to Membership of NHS Boards

The current composition of Greater Glasgow NHS Board comprised twenty-three Directors (fifteen Non Executive Members and eight Executive Members). The guidance set out a number of changes:

- Creation of a new Non Executive position for the Chair of the LHCC Professional Committee – as Board Members, Chairs of LHCC Professional Committees would be expected to play a key role in the transition from LHCCs to Community Health Partnerships.

- Creation of the new Executive position of NHS Board Medical Director – this appointment was intended to complement the role of the NHS Board Nurse Director and the Chairman of the NHS Board was responsible for taking forward the appointment process. The pool of potential applicants eligible to be appointed as NHS Board Medical Director was limited to Medical Directors employed at Divisional level (currently Trusts).

- Transfer of Trust Chief Executive positions to Divisional Chief Executive positions.

- Replacement of the Trust Chair positions by an equivalent number of Lay Member positions – in order to maintain Non Executive capacity in each NHS Board, an equivalent number of new Lay Member positions should be created on each NHS Board concerned – these new lay positions would be filled by open public competition.

- The possibility to create additional Lay Member positions to compensate for the loss of Trustees on Trust Management Teams – a maximum of two additional Lay Member positions may be created for each Trust that was dissolved.

The overall number of Members of NHS Boards should reflect the balance between the desire for inclusiveness and the need to ensure that the Board was of a manageable size, consistent with the effective discharge of business. The arrangements set out in the guidance created a potential Board Member complement in Greater Glasgow of thirty-three.

Mr Divers advised that the Chairman would take early action to secure the appointments of the Chair of the LHCC Professional Committee and the Trust Medical Director as NHS Board Directors. The NHS Board needed to work through the scope and scale of Non Executive responsibilities to inform debate about the complement of Non Executives needed to deliver the functions required, consistent with maintaining a Board of a manageable size. **Chairman**

Mr A Robertson saw the opportunity of further flexibility in working to deliver better services. He was anxious not to underestimate the challenge particularly at the consultation stage when it was paramount to ensure positive messages were given.

(vi) The Development of Operational Divisional Management Teams

The current appointments of Trust Chairs and Trustees would cease automatically on dissolution of NHS Trusts. The position of Executive Members of the Trust Management Teams was different since they were employees of NHS bodies.

ACTION BY

When Trusts were dissolved, the Executive Members would automatically transfer to Divisional Management Teams and would become employees of the NHS Board, in common with all former Trust employees.

Trust Chairs and Trustees whose positions ceased on dissolution of NHS Trusts would be welcome to apply as candidates in open competition for the new Lay Member positions which would be created on the local NHS Board.

The new Divisional Management Team would be chaired by a Non Executive Lay Member of the NHS Board. As the Divisional Management Team would be a Committee of the NHS Board, its chair would be appointed by the NHS Board rather than directly by Ministers.

Trusts' current responsibilities for Clinical Governance would continue to be discharged at Operating Division level. Some former Trust Committees, such as the Audit Committee, would no longer be necessary following the dissolution of Trusts. NHS Boards would, therefore, be expected to review the Committee structures within their Board areas in order to determine how best to discharge the business of the local NHS system.

Mr Divers emphasised that the exercise to scope the responsibilities of Non Executive Directors across NHS Greater Glasgow needed to encompass the Non Executive roles required within Operating Divisions. In addition, there would be new Board level Committees such as the Service Redesign Committee and the proposed Performance and Resources Committee for whose creation the external auditors continued to press.

Mr Divers summarized the legal steps to Trust dissolution in terms of the public consultation which would be conducted in relation to dissolution of Trusts and the transfer of staff, property, rights and liabilities under the terms of the appropriate regulations.

Sir John welcomed the opportunity to do things in a new way – he did, however, acknowledge the challenges that lay ahead. On that point, Councillor McCafferty re-iterated the importance in ensuring the transitional arrangements were clear and precise particularly in terms of audit.

Mr Divers extended an invitation to engage in discussion with himself and the Chairman should any existing Board Member wish to do so.

DECIDED:

- That the report on the Health Department's Guidance on implementing the Health White Paper, Partnership for Care be received and noted.

- That the next steps in taking forward the plans for implementation be noted. **Chief Executive**

33. 2003/4 AND BEYOND CAPITAL ALLOCATIONS

A report of the Director of Finance [Board Paper No 03/18] asked the Board to confirm the capital allocations proposed for 2003/4, totaling £68.9M. Furthermore, the paper sought outline approval for 2004/5, totaling £39.2M so that the allocation was balanced over the two financial years and to confirm the priorities used to determine the schemes proposed for inclusion in the capital programme.

ACTION BY

Responsibility for capital allocations was devolved to NHS Boards in 2002/3. Local approvals processes and procedures were agreed by the Board and the proposals set out had been prepared in line with agreed policy. In reviewing proposals from the Trusts, priority had been given to schemes that:

- Enabled the Acute Services Reconfiguration.
- Ensured ongoing commitments to previously agreed schemes and requirements for regular investment in medical equipment, maintenance, IT, Health and Safety and decontamination.
- Recognised Trust specific priorities.

The timing of schemes had also been scrutinized to ensure that the capital programme was balanced over the two years, 2003/4 and 2004/5.

In response to a question from Councillor Handibode about slippage on primary care developments, Mrs Hull clarified the slippage of £500,000 (page 32 of the Board papers, lines 254 to 257) recognised that the precise timing of completion dates was sometimes difficult to estimate, but over the years there was sufficient flexibility to reprovide for any such amounts.

In a response to a question from Mr P Hamilton, Mr Davison advised that the interim move of Gynaecology services to Glasgow Royal Infirmary was the preferred move for staff and would bring all Gynaecological services together.

Mrs Kuenssberg acknowledged that the Capital Planning Panel was working very effectively and the associated tables showing NHS Greater Glasgow's commitments had been well achieved.

DECIDED:

- That the capital allocations proposed for 2003/4, totaling £68.9M be confirmed. **Director of Finance**
- That outline approval for 2004/5, totaling £39.2M ensuring the allocation was balanced over the two financial years be approved. **Director of Finance**
- That the priorities used to determine the schemes proposed for inclusion in the capital programme be confirmed. **Director of Finance**

34. IMPLEMENTING THE ACUTE SERVICES STRATEGY – PROCUREMENT PROCESS FOR THE AMBULATORY CARE HOSPITALS AT STOBHILL AND THE VICTORIA

A report of the Chief Executive [Board Paper No 03/17] asked the Board to approve:

- that, in terms of the Public Procurement Regulations, the procurement of the Ambulatory Care Hospitals at Stobhill and the Victoria Infirmary should proceed as a Services Contract and that the Services Regulations should apply to the procurement of the project;
- that, in terms of the Services Regulations, the negotiated procedure should be the choice of tendering procedure adopted.

ACTION BY

Sir John welcomed Ms Sharon Fitzgerald, Legal Adviser from Bevin Ashford and Shepherd Wedderburn who had been appointed to assist the Board with the procurement process.

Ms Fitzgerald advised that in considering which set of Public Procurement Regulations should apply to the Project, it was recognised that the Project would constitute a "mixed" contract involving a combination of both works and services. In determining whether to apply the Public Works Contracts Regulations 1991 (as amended) or the Public Services Contracts Regulations 1993 (as amended) (the "Services Regulations"), the Board had to apply the "main object/primary purpose" test and the "relative value" test to determine the correct Regulations for the Project.

In applying the main object/primary purpose test, the Board acknowledged that it would identify the scope of the Project in terms of the service outputs required rather than focusing on the form of delivery of the Project. Given that the Board was looking for the delivery of a "serviced" accommodation over a 30 year contract period, the Board had concluded that the main object of the Project was the delivery of a service rather than the provision of works.

The test of "relative value" involved a comparison of the works/construction costs of the Project with the cost of the services elements. As part of the preparation of the Outline Business Case for the project, these costs were assessed over a contract term of thirty years. The assessment showed that the services element outweighed the works element over the thirty year life assumed for the Project.

On the basis of the outcome of the "main object/primary purpose" test and the "relative value" test, the Board had concluded that the Project was a services contract and that the Services Regulations should apply to the procurement of the Project.

The Board's Executive Directors involved in taking this project forward concluded that it would not be appropriate to select the open or restricted tendering procedure for use on this Project. It was proposed that the Board should choose the negotiated procedure for the following reasons:

- The nature of the services or the associated risks did not permit prior overall pricing.

- The nature of the services was such that specifications could not be drawn up with sufficient precision to permit the award of the contract using the open and restricted procedures.

The decision to follow the negotiated procedure under the Services Regulations followed the advice of the Board's Legal Advisers and was in line with Treasury Guidance.

The Board's Legal Advisers had prepared the Official Journal of the European Community (OJEC) Notice for the Project on the basis that the Service Regulations applied and on the basis that the negotiated procedure would be utilised. The Board's formal agreement to the recommendations would see the procurement advert appear shortly, ahead of an Open Day on 1 April 2003 which had been arranged for developers potentially interested in the project.

In response to a question from Dr Nugent, Ms Fitzgerald clarified the term "mixed" contract and "negotiated" procedure. The negotiated procedure was more interactive and allowed more flexibility particularly as the price was decided before the Project started and the Board would retain contractual control.

ACTION BY

In response to a question from Professor Farthing, Ms Fitzgerald confirmed that the Legal Advisers had already identified a number of potential bidders who would attend the Open Day on 1 April 2003 – as such they could only assume that the Project was attractive to bidders and that they could deliver on time.

Mr Calderwood clarified for Councillor Handibode the difference between soft FM and hard FM services. The procurement route recommended gave the NHS Board the most flexibility in determining the final shape of the contract and he did not anticipate any current staff suffering any detriment to their employment conditions. The OJEC advert at this stage included soft FM services. Mr Goudie and Councillor McCafferty indicated the concerns that they would have if soft FM services were included in the contract. Mr Divers briefly outlined the National policy framework which directed their inclusion.

Ms Fitzgerald confirmed that there were vigorous evaluation criteria which would be structured specifically to take account of all concerns raised.

DECIDED:

- That, in terms of the Public Procurement Regulations, the procurement of the Ambulatory Care Hospitals at Stobhill and the Victoria Infirmary should proceed as a services contract and that the Services Regulations should apply to the procurement of the Project. **Chief Executive**

- That, in terms of the Services Regulations, the negotiated procedure should be the choice of tendering procedure adopted. **Chief Executive**

35. NHS HDL 2002 (82)

Dr Burns opened by referring to the recent case in Manchester of respiratory problems which had originated in the Far East. Symptoms included high temperature and severe muscle pains and had been fatal in a significant number of cases. Furthermore, it had been apparent that nursing staff had gone on to get the symptoms indicating that the virus may be infectious. It was not known yet what kind of organism this was although it may have arisen from the Middle East where a high density population live close to domestic animals. So far, this had not been an issue for Greater Glasgow but all medical staff had been asked to be vigilant

A report of the Director of Public Health [Board Paper No 03/19] asked the Board to note the response sent to the Scottish Executive, prepared by the Area Control of Infection Committee, on behalf of Greater Glasgow NHS Board, in collaboration with all the Trusts in Greater Glasgow. Dr McMenamin, Consultant in Public Health Medicine, introduced the report.

NHS HDL 2002 (82) highlighted recommendations from two reports for the management of health care associated infection:

- Ministerial Action Plan on Care Associated Infection.

- Watt Group Report on the Outbreak of Salmonella Infection at Victoria Infirmary.

The Watt Group Report included 47 recommendations for action by the NHS Trusts/Boards and other bodies including the Scottish Executive, to improve the efficiency and effectiveness of infection control arrangements and of hospital cleaning services. The Ministerial Action Plan contained further recommendations as well as endorsing the conclusions of the Watt Report.

ACTION BY

The Board's response to the Health Department Letter highlighted the increasing emphasis on staff education, audit and updating of various outbreak plans, as well as progressive investment in infection control nursing staff. All Glasgow Trusts, in response to the Watt Group Report, also requested additional resources to improve the infrastructure of their infection control teams including additional medical microbiology support, clerical support and surveillance nurse support.

The Area Control of Infection Committee had agreed a standard formula based on international recommendations, however, it had not completed its review of other resources required by Trusts in Greater Glasgow for infection control infrastructure. Once this had been completed, the Area Control of Infection Committee would produce a further report for the NHS Board highlighting any other deficiencies in infection control staffing in NHS Greater Glasgow.

In response to a question from Mr Goudie, Dr McMenamin confirmed that the hand hygiene audit did not refer to the facilities but to auditing individuals.

In response to a question from Councillor Handibode, Mr Divers confirmed that in terms of the negotiated procedure agreed for the procurement of the two Ambulatory Care Hospitals, the Board could impose such new hygiene and other regulations on contractors.

Dr Nugent emphasised that in terms of hand hygiene, this also related to a cultural change emphasising the importance of good practice as for other more high profile issues. Furthermore, Dr McMenamin confirmed that there were implications for ward design and the Scottish Executive Health Department had issued guidance on minimal bed space that was appropriate. Overall, there were vast implications for implementing the new culture of hygiene across NHS Greater Glasgow, putting in place associated training and budgets and ensuring that management systems and audit systems were in place to counter balance these.

DECIDED:

That the response sent to the Scottish Executive Health Department Letter be noted.

36. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/20] noted progress towards delivering the Board's agreed over nine month waiting time reduction.

There had been a reduction of 23% in NHS Greater Glasgow residents with a guarantee waiting over 9 months between January 2003 and February 2003 – this showed significant progress towards meeting the December 2003 target.

Various pressures on both North and South Trusts which had a potential impact on waiting times included theatre maintenance, compliance with the recommendations of the Glennie Report, nursing vacancies, temporary closure of beds and delayed discharges. These continued to affect progress towards the December 2003 target.

Allocation of activity at the Golden Jubilee National Hospital and within the private sector in Glasgow would help to alleviate some of these pressures.

NOTED

ACTION BY

37. 2002/2003 FINANCIAL MONITORING REPORT FOR TEN MONTHS ENDED JANUARY

A report of the Director of Finance [Board Paper No 03/21] asked the Board to note the results reported for the ten months ended 31 January 2003.

Mrs Hull confirmed that Greater Glasgow's Trusts were reporting a £1.019M deficit against the break-even target for the ten months to January 2003. Overall, therefore, the position remained in line with that forecast and it was still anticipated that the total estimated £2M overspend against Trusts' startpoint allocations could be offset by reserves available at the year end.

NOTED

38. QUARTERLY REPORTS ON COMPLAINTS : OCTOBER - DECEMBER 2002

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No 03/22] asked the Board to:

- Note the quarterly report on NHS complaints in Greater Glasgow for the period 1 October to 31 December 2002 (Appendix A).
- Note the extract from the Information Service Division's (ISD) Annual Report entitled "NHSScotland Complaints Statistics – Year Ending 31 March 2002" (Appendix) B).
- Approve the extension to the Terms of Office of ten Lay Chairs and six Lay Conciliators (Appendix C).
- Approve the NHS Greater Glasgow Habitual and/or Vexatious Complaints Policy (Appendix D).
- Note the attached draft consultation document "Reforming the NHS Complaints Procedure" issued by the Scottish Executive (Appendix E).

Sir John noted that no Trust met the national target of 70% of written Local Resolution complaints to be completed within 20 working days of receipt.

Mr J Hamilton referred to the consultation document issued by the Scottish Executive Health Department "Reforming the NHS Complaints Procedure". Comments were invited by the Scottish Executive by 2 June 2003 and the consultation document had been widely distributed throughout NHS Greater Glasgow. A seminar for all those interested in complaints had been arranged for Thursday 15 May 2003 (9.00 am to 11.00 am) in order that the proposals within the consultation document could be presented and feedback received. This would allow the Board to finalise its response to the consultation document.

Sir John asked that the draft Board response be considered by the Board at its meeting scheduled in May 2003 prior to submission to the Scottish Executive. **Head of Board Administration**

DECIDED:

- That the quarterly report on NHS complaints in Greater Glasgow for the period 1 October to 31 December 2002 be noted.

ACTION BY

- That the extract from the Information Service Division's (ISD) Annual Report entitled "NHSScotland Complaints Statistics – Year Ending 31 March 2002" be noted.

- That the extension to the Terms of Office of ten Lay Chairs and six Lay Conciliators be approved. **Head of Board Administration**

- That NHS Greater Glasgow Habitual and/or Vexatious Complaints Policy be approved. **Head of Board Administration**

- That the draft consultation document "Reforming the NHS Complaints Procedure" issued by the Scottish Executive be noted and the arrangements to respond to the document be endorsed. **Head of Board Administration**

39. CORPORATE GOVERNANCE FRAMEWORK

A report of the Head of Board Administration [Board Paper No 03/23] asked the Board to note that in its annual review there were no changes proposed to the Corporate Governance Framework (with the exception of the amendments to the Register of Members Interests) and authorise the Board Chairman to approach and appoint, where necessary, NHS Board Members to vacancies on Standing Committees ensuring the smooth and effective operation of the Board's business.

DECIDED:

- That the annual review of the Corporate Governance Framework and amendments to the Register of Members Interests be noted. **Head of Board Administration**

- That the Board Chairman be authorised to approach and appoint, where necessary, NHS Board Members to vacancies on Standing Committees to ensure the smooth and effective operation of the Board's business. **Board Chairman**

40. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 03/24] was submitted seeking approval of two medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr John Khaukha
Dr Colin Preshaw

41. MINUTES OF THE AUDIT COMMITTEE

The Minutes of a meeting of the Audit Committee [A(M)03/1] held on Tuesday 28 January 2003 were noted.

ACTION BY

42. MINUTES OF THE RESEARCH ETHICS GOVERNANCE COMMITTEE

The Minutes of a meeting of the Research Ethics Governance Committee [NHSGGREGC(M)03/1] held on Friday 31 January 2003 were noted.

The meeting ended at 12.20 pm

GGNHSB(M)03/4
Minutes: 43 - 53

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 15 April 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Best	Councillor J Gray
Dr H Burns	Mr P Hamilton
Mr R Calderwood	Mrs W Hull
Mr R Cleland	Mrs S Kuenssberg CBE
Councillor D Collins	Mrs R K Nijjar
Mr T A Divers OBE	Dr J Nugent
Councillor R Duncan	Mr A O Robertson OBE
Mr W Goudie	Mrs E Smith

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

Mr T Findlay	Greater Glasgow Primary Care NHS Trust (to Minute 50)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms C Renfrew	Director of Planning and Community Care
Mr J Whyteside	Public Affairs Manager

B Y I N V I T A T I O N

Mr S Bryson	Representative, Area Pharmaceutical Committee (to Minute 50)
Mr J Cassidy	Chair, Area Nursing and Midwifery Committee
Dr R Hughes	Chair, Area Medical Committee
Mr J McMeekin	Vice Convener, Greater Glasgow Health Council
Mr H Smith	Chair, Area Allied Health Professionals Committee

ACTION BY

43. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Ms R Crocket, Mr T Davison, Professor M Farthing, Mr I Reid, Ms E Borland, Mr A McLaws, Mrs C Anderson (Chair, Area Pharmaceutical Committee), Dr F Angell (Chair, Area Dental Committee), Mrs P Bryson (Convener, Greater Glasgow Health Council) and Ms G Leslie (Vice Chair, Area Optometric Committee).

The Chairman welcomed new NHS Board Members Peter Hamilton, Ravindar Kaur Nijjar and John Nugent. Mrs Pat Bryson had been appointed as Greater Glasgow Health Council's new Convener and was represented at the meeting by the new Vice Convener, John McMeekin.

ACTION BY

44. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

(a) The procurement launch for the two Ambulatory Care Hospitals (ACADs) had been held at Hampden Park on 1 April 2003; this had been well attended. The Chief Executive would include the key milestones in the procurement plan in his next quarterly update to the Board.

A first meeting had taken place on 28 March 2003 of the two Monitoring Groups set up by the Minister for Health and Community Care to take forward the monitoring of the continuation of "named services" within Stobhill Hospital and the Victoria Infirmary, during the period prior to the rationalization of inpatient services. Both Monitoring Groups had agreed a remit of operation and a cycle of meetings.

(b) At the request of Councillor Handibode, Dr Burns had contacted the Chief Executive and Director of Operations at Scottish Water concerning the transfer from Glasgow to Edinburgh of water testing functions. Dr Burns had been assured that the testing systems for cryptosporidium would remain at its present level and Scottish Water would ensure that the level of service was maintained with regular reports being carried out without interruption. To date there had been no schedule for the transfer but the NHS Board would be kept advised of developments.

(c) Sir John and Mr Divers had had a series of discussions with providers of training and education in relation to taking forward Greater Glasgow's manpower requirements with Universities and education establishments. This series of events had started with Learning Direct.

Sir John had chaired several meetings in relation to the creation of a Centre of Population Health – working in partnership with Greater Glasgow's Universities and health care establishments. The remit of the Centre would be based on three components:

- research
- policy
- education and training

and all scientists and experts were committed to making it work. This was a positive reflection on what Glasgow had learned regarding social and health issues and provided a platform to build on this momentum.

(d) Sir John asked the Board to note the Declaration of Interest of the three new Board Members.

NOTED

ACTION BY

45. CHIEF EXECUTIVE'S UPDATE

Mr Divers advised that there had been an Area Partnership Forum Away Day on 9 April 2003 to discuss taking forward the partnership working implications in the recent White Paper – "Partnership for Care". The event had been facilitated by Frontline Scotland and an action plan formed. It would be passed to the Staff Governance Committee. A follow-up half-day seminar had been arranged for 30 May 2003 to take forward the action plan.

NOTED

46. MINUTES

On the motion of Dr H Burns, seconded by Mr A O Robertson, the Minutes of the meeting of the NHS Board held on Tuesday 18 March 2003 [GGNHSB(M)03/3] were approved as an accurate record and signed by the Chairman.

47. MATTERS ARISING

Members were circulated with the rolling action list which updated on the progress and timescale for ongoing matters arising.

Further guidance had been received from the Scottish Executive Health Department on establishing Service Redesign Committees. Councillor Collins asked that in considering Non Executive Members to new Committees, this be deferred until after the Local Authority elections on 1 May when it would become clearer which Local Authority Councillors would be Members of the NHS Board. Mr Divers agreed to take this on board. **Chief Executive**

Sir John updated Members on the following appointments to vacancies on Standing Committees:

Charles Scott – appointed as Convener of the Audit Committee
Peter Hamilton – appointed as a Member of the Audit Committee
Ravindar Kaur Nijjar – appointed as a Member of the Research Ethics Governance Committee

NOTED

48. IMPLEMENTING JOINT FUTURES : OUTCOME OF CONSULTATION ON INTEGRATION OF SERVICES – EAST DUNBARTONSHIRE

A report of the Director of Planning and Community Care [Board Paper No 03/25] asked the Board to note the outcome of the above consultation and ratify the proposed way forward outlined by the Joint Planning Forum.

Ms Renfrew reminded the Board that at its December 2002 meeting it approved for consultation proposals to move to integrated service delivery arrangements within East Dunbartonshire Council.

Ms Renfrew led the Board through the responses to the consultation and highlighted the four recommendations already endorsed by the Joint Planning Forum:

ACTION BY

(i) The early establishment of a Shadow Joint Health and Social Care Committee.

(ii) The recruitment of a Head of Health and Community Care.

(iii) The establishment of a Project Steering Group charged with managing the initial change programme.

(iv) Immediate and ongoing communication with stakeholders.

The outcome of the consultation had already been considered and approved by the Joint Planning Forum with East Dunbartonshire Council which brought together Board Members, Local Councillors, the voluntary sectors and Local Health Care Co-operative (LHCC) representatives.

From the responses to consultation it was clear that there was broad support for the further integration of services but a recognition that a significant amount of work remained to be done on the detail. The recommendations to the Joint Planning Forum would address the Council's need for capacity and leadership to direct the next stage of development.

East Dunbartonshire Council's objective was that the four recommendations would enable it to address, in final proposals, the key issues from consultation including:

- Achieving local accountability for mental health within a system-wide approach.
- A relationship of the structure to children's services.
- A balance of locality and East Dunbartonshire wide arrangements.
- Whether planning and commissioning was included in the joint head's remit as well as operational management.
- Evolution paths for LHCCs including cross boundary issues.
- Maintaining and strengthening devolution and delegation.
- Achieving best standards of governance and professional accountability.

In considering these recommendations, Ms Renfrew asked the Board to reflect on the three issues most significant to the NHS:

(i) Had the consultation process been appropriate and engaging?

(ii) Whether the issues raised by the responses of NHS interests had been adequately addressed by the recommendations?

(iii) A desire to see much more detailed proposals on governance and professional accountability arrangements for individual staff.

ACTION BY

The proposed way forward and these points outlined gave a firm commitment to reflect carefully on consultation responses in moving forward to implement an integrated structure. The essence of what was proposed was to create leadership and capacity to work through the detail of an integrated structure in a way which could address the issues and concerns people had raised. The full integration would be implemented at the end of this development phase, which would be steered by a Project Group bringing together the main constituencies of interest. Critically linked to that process would be a focus on communication and continuing engagement of key stakeholders.

Ms Renfrew assured the Board that it could be confident the consultation process had fully engaged health staff and that the issues and concerns raised in consultation could be addressed by the recommendations – without mitigating the Board's commitment to move to integrated service delivery which would improve the experience of patients and users.

Councillor Duncan confirmed that East Dunbartonshire Council was committed to the process of delivering a range of community based health and social services in its geographical area. The Council had been impressed with the outcome of the consultation and was optimistic to press forward.

Mr Robertson advised that the Primary Care Trust was committed to the principles and direction of travel but recognised the concerns expressed by staff. He was encouraged by the emphasis on the development process, particularly appointing a Head of Health and Community Care – to lead the development process with a fully representative project team.

Mr Robertson further noted the importance of a very inclusive further process before the transfer of operational management responsibilities to the Head of Health and Community Care. Ms Renfrew highlighted the detail of the four recommendations as covering the further development work to lead to a definitive final structure. Mr Divers confirmed that if the expanded recommendations covered the ground required, that would enable ratification of the Joint Planning Forum's conclusions.

Dr Nugent outlined the significant staff challenges that lay ahead and sought more clarity around the control outcomes of the integrated working. Ms Renfrew referred to the measurable outcomes on pages 33 and 34 of the Board papers particularly in relation to older people, mental health and physical disability.

Mr Goudie encouraged the Local Authority and Primary Care Trust to work in partnership to address any practical problems on the staff side – one way to alleviate this would be to ensure that a staff representative was a member on the Joint Planning Committee. In response to this, Ms Renfrew advised that there was a strong relationship between the NHS and East Dunbartonshire Council where partnership working was active.

Councillor Collins commended this as a fine example of joint working and encouraged a roll-out of the good practice arrangements throughout other Council areas.

Sir John echoed the views already expressed in terms of the challenge of joint working that lay ahead particularly now that the concept and plan had been devised – the delivery would remain complex but exciting.

ACTION BY

DECIDED:

- That the outcome of the consultation on joint future implementation – integrated services for East Dunbartonshire Council be noted. **Director of Planning and Community Care**

- That the proposed way forward outlined in the paper (already endorsed by the Joint Planning Forum) be ratified as follows: **Director of Planning and Community Care**

1. The proposal for the establishment of a Joint Health and Social Care Committee received widespread support. It was proposed, therefore, that a Shadow Joint Committee be established in line with the recommendations in the proposal. The Shadow Committee should be constituted as early as possible to oversee the change programme.

2. The recruitment of the Head of Health and Community Care should be progressed. Without the capacity such a post would create the NHS Board could not address the agenda of detailed work, which the consultation process, quite rightly, highlighted as required and which must be completed to deliver the integrated services which most people supported. The postholder's initial focus, estimated over the first twelve months, would be to develop and refine the integration proposal in light of the feedback from the consultation, working with the Project Group. The operational management of services would remain within the current configuration during that development phase. Thereafter, the Head would assume management responsibility and accountability, for the agreed range of services and the structure established in the development phase, reporting to the Joint Executive Group and through that to the Joint Committee. The final service and structure would be subject to East Dunbartonshire Council and Greater Glasgow NHS Board approval before the transfer of management responsibilities.

3. A small project steering group with senior colleagues to represent East Dunbartonshire Council (Social Work and Corporate Services), the Primary Care Trust, the LHCCs and GGNHSB should be convened to manage the initial change programme. Immediate priorities would include:

    - the establishment of the Joint Committee
    - the process of finalising the remit and recruitment to the post of Head of Health and Community Care
    - development of the concept and functionality of a joint executive group
    - consideration and establishment of a joint integration support function (including existing and additional capacity) to address issues from the consultation around:
        - human resources
        - information sharing and information technology
        - finance
        - performance and clinical governance

4. To ensure immediate and ongoing communication with stakeholders. Initially this would involve the next edition of the joint newsletter and Joint Future Update Seminar planned for 15 April 2003.

49. PRIMARY CARE ACCESS STRATEGY UPDATE

A report of the Chief Executive, Greater Glasgow Primary Care NHS Trust [Board Paper No 03/26] asked the Board to:

ACTION BY

- Note the progress being made on access initiatives within the Primary Care Trust and to endorse continuation of the approach adopted.

- Note that practice redesign and triage training costs were not directly funded by the Scottish Executive and, as such their financing would need to be considered in finalising the priorities for the Local Health Plan.

The Chairman welcomed Terry Findlay, Greater Glasgow Primary Care NHS Trust who described the aims of the strategy. These were to improve access to services across a range of measures and at the same time support the short-term goal of ensuring access to an appropriate member of the primary health care team within 48 hours by April 2004.

He updated on the short term initiatives designed to meet the 48 hour commitment and referred to the achievements in respect of the overall strategy that had been documented in the Primary Care Strategy Phase 2. In the longer term, the access strategy was concerned with a fundamental rethink and redesign of services within primary care towards streamlining ways that patients may access these services. The long and medium term initiatives in the Access Strategy were an integral part of this.

Mr Findlay described the current situation and the two major stages in meeting the April 2004 position, that of practice redesign and assessment and triage. He was confident that by April 2004, sixty GP practices would have completed the programme for practice redesign with a further sixty giving a commitment for the following year. Seventy practices would have conducted and instigated telephone triage which would change the dynamics of service provision.

The current state of knowledge about timely access to services was growing but still insufficient to adequately monitor performance against the 48 hour target. At best, the Primary Care Trust could assume that 25% of practices were unable to meet the access target. The two main short term strategies of practice design and triage would advance significantly in the course of the next year and would, if other UK experience was consistent in Greater Glasgow, be able to address this short-fall as well as providing more confident measures of performance.

Dr Nugent referred to the major redesign pressure and highlighted that although Primary Care Trust teams were working very hard, it was paramount to identify what could be done smarter and better.

Mr P Hamilton referred to the disappointing uptake of only 50% of practices who had responded to the initial GP appointment stock take undertaken in June 2002. In response to a question from Mr Hamilton, Mr Findlay confirmed that one alternative method of data collection being explored was the “mystery shopper” method when someone from the Primary Care Trust could telephone a practice and ask for their earliest appointment. He was, nonetheless, confident that the Primary Care Trust would receive the relevant information from the majority of practices once it had been made clear what the information was being used for. He also described how patient satisfaction was measured in relation to the pilot trials in that a survey would be undertaken to determine usefulness.

Councillor Collins sought alternative methods to encourage all practices to respond to the stock take to ensure that the data received was relevant and to determine the Greater Glasgow wide picture particularly as decisions would be made on the data – if it had not been accurately measured it could not be accurately managed.

ACTION BY

Mr Divers set the goals of the strategy in the strategic context of the White Paper and the GMS contract which would ensure robust ways of engagement and incentives with practices. Furthermore, there were qualitative standards to ensure practice participation and this was a further opportunity to extract the data.

Sir John referred to the enthusiasm to take forward the pilot although recognised the challenge in engaging practices to work with the Trust to obtain the relevant information. He highlighted that there were benefits and positive outcomes for practices and patients in the success of this strategy.

DECIDED:

- That the progress being made on access initiatives within the Trust be noted and the continuation of the adopted approach be endorsed. **Chief Executive, GGPCNHST**

- That as practice redesign and triage training courses were not directly funded by the Scottish Executive, financing issues would need to be considered in finalising the priorities for the Local Health Plan. **Chief Executive, GGPCNHST**

- That Dr Nugent discuss the issues raised further at the next LHCC Committee meeting. **Chair, LHCC Committee**

- That a further update report be brought to the NHS Board in six months. **Chief Executive, GGPCNHST**

50. PUBLIC HEALTH ISSUE – GGNHSB CERVICAL SCREENING PROGRAMME – ANNUAL REPORT 2001/2002

A report of the Director of Public Health [Board Paper No 03/27] asked the Board to note the above report which outlined the performance of the screening programme within Greater Glasgow.

This was the twelfth annual report of the screening programme and Dr Burns referred to the steady progress in improving uptake. Women were sent invitations to be screened at least every five years (although, in practice, it was usually within three years). The Board measured uptake within sequential 5½ year periods since this was agreed as the time limit within which women should be invited and should attend for smears. Within the 5½ year period to 31 March 2002, the screening uptake was 83%. Within the same period leading to 31 March 2001, uptake was 81%. Dr Burns explained that uptake was related to deprivation status and in the year ended 31 March 2002, uptake improved in each deprivation category, reaching 88% in DepCat 1 and 80% in DepCat 7. The number of GP practices reaching over 80% uptake had improved from 69% last year to 78% this year.

Recent review of the screening programme had suggested ways in which the Board could improve the effectiveness of its reporting arrangements. There were also national programmes for the introduction of new technology for assessing the results of smears. This should lead to a reduction in the number of unsatisfactory smears when women were required to attend for a second examination. The Board also awaited a national call/recall system which would standardize processes and protocols across Scotland to develop a single national IT system – it was hoped this would be introduced within the next year.

Dr Burns referred to the recent inspection undertaken by NHS Quality Improvement Scotland – the report of which was awaited.

ACTION BY

In terms of extracting relevant information from the current IT systems, this matter had been raised with Greater Glasgow's NHS Trusts to ensure that maximum use was made of the data available. Furthermore, Mrs Hull referred to the ICT Strategy and the strategic direction of travel in abstracting information to address clinical needs.

Dr Burns referred to the "did not attend (DNA)" rate and ways of looking at reducing this and ensuring women took the opportunity to look after their health.

Dr Hughes referred, in general, to the increasing DNA rates across all specialties in Greater Glasgow which presented significant problems across the board. Any incentive/sanction to alleviate this would be difficult to enforce. Dr Nugent referred also to the fact that smear tests were not compulsory and that women did have a choice on whether to attend. It was recognised, however, that in exploring ways to reduce DNA rates, there were implications for effective management and secretarial services in terms of resources and organisation.

DECIDED:

That the GGNHSB Cervical Screening Programme – Annual Report 2001/2002 be noted.

51. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/28] noted progress towards delivering the Board's agreed over nine-month waiting time reduction. There had been a reduction of 37% in NHS Greater Glasgow residents with a guarantee waiting over 9 months between February 2003 and March 2003 – this showed significant progress towards meeting the December 2003 target. Furthermore, the March guarantee position reflected a 50% reduction since April 2002.

Ms Renfrew referred to the planning processes in place to ensure that the Board continued to move towards these commitments including:

- Maximum wait for inpatient and day case treatment of 9 months by December 2003.
- Maximum wait for inpatient and day case treatment of 6 months by December 2005.
- Maximum wait for outpatient appointments of 26 weeks by December 2005.

NOTED

52. 2002/03 FINANCIAL MONITORING REPORT FOR ELEVEN MONTHS ENDED FEBRUARY

A report of the Director of Finance [Board Paper No 03/29] asked the Board to note the results reported for the eleven months ended 28 February 2003.

Trusts were reporting a £2.557M deficit against the break-even target for the eleven months to February 2003. It was still forecast that a break-even position would be achieved for the full year and the reported overspend at the Primary Care Trust would be funded from brought forward reserves.

ACTION BY

Sir John referred to the significant effort of financial management on the part of the four Greater Glasgow NHS Trusts and NHS Board staff – he congratulated all for their efforts.

Mr Robertson sought clarification around the figures shown for health promotion/other services and Board Headquarters. Mrs Hull agreed to report back on the detail of these figures. **Director of Finance**

DECIDED:

That the results reported for the eleven months ended 28 February 2003 be noted.

53. ETHICAL STANDARDS IN PUBLIC LIFE – CODE OF CONDUCT FOR NHS BOARD MEMBERS

A report of the Head of Board Administration [Board Paper No 03/30] asked the Board to:

- Note the requirement that Members re-familiarise themselves with the Code of Conduct for Members of Greater Glasgow NHS Board.
- Agree to the appointment of the Head of Board Administration as the "Standards Officer" under Section 7.1 of the Act.
- Approve the amendment to Standing Order 11.
- Note the requirement associated with the completion of the Declaration of Interests and that the Head of Board Administration would write to all Members shortly on the completion of their Declarations.
- Note the additional guidance provided by the Standards Commission for Scotland on the Ethical Framework – Relationship between Standards Commission and Public Bodies, Duties of Public Bodies and to Promote High Standards of Conduct and the Register of Interests.

Mrs Smith referred to the Guidance issued by the Standards Commission for Scotland and the Act which introduced a new ethical framework for public life in Scotland.

The model code of conduct had been adopted by the NHS Board in July 2002 and its impact on the Register of Members' Interests had been referred to in the review of the Corporate Governance Framework which was submitted to the October 2002 and March 2003 NHS Board meetings. Now that the Code of Conduct had been formally agreed by Ministers, there were a number of actions which needed to be put in place.

DECIDED:

- That the requirement on Members to re-familiarise themselves with the Code of Conduct for Members of Greater Glasgow NHS Board be noted.
- That the appointment of the Head of Board Administration as the "Standards Officer" under Section 7.1 of the Act be agreed. **Head of Board Administration**
- That the amendment to Standing Order 11 be approved. **Head of Board Administration**

ACTION BY

- That the requirement associated with the completion of the Declaration of Interests be noted and that the Head of Board Administration write to all Members shortly on the completion of their Declarations be agreed. **Head of Board Administration**

- That the additional guidance provided by the Standards Commission for Scotland on the Ethical Framework be noted.

The meeting ended at 11.15 am

GGNHSB(M)03/5
Minutes: 54 - 68

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 20 May 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr H Burns	Mr P Hamilton
Mr R Calderwood	Councillor J Handibode
Councillor D Collins	Mrs S Kuenssberg CBE
Ms R Crocket	Mrs R K Nijjar
Mr T Davison	Dr J Nugent
Mr T A Divers OBE	Mr A O Robertson OBE
Mr W Goudie	Mrs E Smith

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

Dr S Ahmed	Consultant in Public Health Medicine (for Item 63)
Ms E Borland	Acting Director of Health Promotion
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Planning and Community Care
Mr J Whyteside	Public Affairs Manager

B Y I N V I T A T I O N

Dr F Angell	Chair, Area Dental Committee
Mr J Cassidy	Chair, Area Nursing and Midwifery Committee
Ms G Leslie	Chair, Area Optometric Committee
Ms M Wilmot	Vice Chair, Area Allied Health Professionals Committee

N H S 2 4 R E P R E S E N T A T I V E S

Ms M Brannan	Communications Manager
Dr L Duncan	Associate Medical Director
Mrs C Lenihan	Chairman
Ms E Muir	Deputy Director of Nursing

ACTION BY

54. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr J Best, Mr R Cleland, Councillor R Duncan, Professor M Farthing, Councillor John Gray, Councillor J Handibode, Mrs W Hull, Mrs C Anderson (Chair, Area Pharmaceutical Committee), Mr H Smith (Chair, Area Allied Health Professional Committee) and Dr B West (Chair, Area Medical Committee).

The Chairman welcomed representatives from NHS24 who were in attendance to present to the NHS Board the progress since NHS24 was launched within Greater Glasgow in November 2002.

In noting Councillor J Gray's apologies, the Chairman acknowledged it would have been his last meeting representing Glasgow City Council. He thanked Councillor Gray for his valuable contribution to the Board and in particular his leadership in taking partnership working forward especially in Learning Disabilities and the relocation of patients from Lennox Castle Hospital.

55. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

(a) Both the national and local elections had been concluded and the Chairman had written to all elected MSPs within Greater Glasgow to confirm his intention to have quarterly meetings with them. This was welcomed by the Board.

With regard to the local elections, he congratulated the Councillors on the NHS Board who had been successfully retained by their local electorate. New Council nominations from Glasgow City and West Dunbartonshire were awaited.

(b) The Chairman congratulated the NHS Board Corporate Communication Team and Partnership Co-ordinator for the production of NHS Greater Glasgow's Staff News – Issue 1. This was a new staff magazine inspired and written by staff for staff and had the full support of the Partnership Forum. Mr McLaws had received positive feedback about the newspaper. In response to a question from Councillor Collins, it was agreed that the magazine should be distributed to Greater Glasgow's Health Centres via the Primary Care Trust. In connection with the NHS Health Newspaper, Mr McLaws advised that the next edition was due mid June.

(c) The Chairman had arranged a meeting with Professor Sir G Davis and colleagues from Glasgow University and external advisers in taking forward the creation of a Centre of Population Health in Glasgow.

NOTED

ACTION BY

56. CHIEF EXECUTIVE'S UPDATE

Mr Divers advised that there had been a meeting of NHS Board Chief Executives to develop thinking on regional planning arrangements arising from the NHS White Paper 'Partnership for Care'. This had been a productive session with the group looking at the key issues to work through the formulation of arrangements.

NOTED

57. MINUTES

On the motion of Mr R Calderwood, seconded by Dr J Nugent, the Minutes of the meeting of the NHS Board held on Tuesday 15 April 2003 [GGNHSB(M)03/4] were approved as an accurate record and signed by the Chairman.

58. MATTERS ARISING

Members were circulated with the rolling action list which updated on the progress and timescale for ongoing matters arising.

NOTED

59. NHS24 - PRESENTATION

The Chairman welcomed Mrs C Lenihan, Chairman, NHS24 who in turn introduced Dr L Duncan, Associate Medical Director, Ms E Muir, Depute Director of Nursing and Ms M Brannan, Communications Manager.

Mrs Lenihan explained that although NHS24 was a new member of the NHS family, it worked within the same policy context, providing 24 hour access to health information and advice over the telephone.

She described the NHS24 core services which centred around the needs of individual patients when their call was received. Tier 1 of the service involved the call handler assessing whether the patient required healthcare information and advice or a nurse led consultation. Tier 2 involved integration with other bodies such as the Scottish Ambulance Service, A & E Departments and the out of hours GEMS Service. Tier 3 comprised the aspirational connections for NHS24 and looked at services such as dental treatment, pharmacy, community nursing and midwifery.

In terms of service provision in Greater Glasgow, Dr Duncan advised that NHS24 received on average 5,000 calls per week – 99% of these calls were answered in less than 30 seconds and the total call duration was 10 to 12 minutes on average. In terms of out of hours outcomes, 3% were transferred to the Scottish Ambulance Service, 5% to A & E and 60% to the patient's GP.

Dr Duncan advised that NHS24 received regular feedback from partner organisations which often highlighted how improvements could be made particularly in relation to demography accuracy and inappropriate referrals. Furthermore, an analysis was ongoing on the IT systems with modifications being carried out currently. In terms of future developments, NHS24 were looking to expand into the areas of dental advice and referral, and protected learning time cover for GP practices.

ACTION BY

Dr Duncan thanked NHS Greater Glasgow for working in partnership with NHS24 to support its learning as it sought to improve the quality of its service.

In response to a question from Sir John, Dr Duncan confirmed that the IT providers were fulfilling their contract albeit that there had been a few minor unexpected difficulties with the operating and communication links. NHS24 had a paper back-up system which they had relied on for short periods of time when the system had been down – at no time had there been an adverse effect to patients and system modifications were being made to remedy this.

Mrs Lenihan explained that NHS24 had looked at scenario planning anticipating strategies such as disaster recovery and were satisfied that calls could switch between the three NHS24 centres in Scotland ensuring full business continuity.

In response to a question from Ms Crocket, Ms Muir confirmed that direct referrals could now be made to Community Psychiatric Nurses (CPNs) via the NHS24 IT system. As it was at the moment, there was no planned date for further roll-out of NHS24 in the West of Scotland. Ms Muir confirmed that she was happy with the staff complement as it stood at the moment and 10% of staff who were working full-time now worked part-time in an effort to continue experience of clinical nursing.

In response to a question from Mrs Nijjar, Ms Brannan confirmed that NHS24 used a language line service which allowed them to access around 200 different languages.

In response to a question from Mr Reid, Mrs Lenihan advised that the NHS24 Board would be looking soon at the demographics of those using its service to establish if there were any pockets where further work could be done to raise awareness of NHS24.

In response to a question from Mr Goudie, Ms Muir advised that there was a national partnership group within NHS24 and furthermore a local one in each centre.

The Chairman thanked the NHS24 staff for attending the Board and giving a very informative update of ongoing progress.

NOTED

60. IMPROVING HEALTH IN SCOTLAND : THE CHALLENGE

A report of the Acting Director of Health Promotion [Board Paper No 03/31] asked the Board to note the main element of "Improving Health in Scotland : The Challenge" and the work underway in Greater Glasgow to address this challenge as well as considering the Local Health Plan Steering Group recommendations as contained in section 4 of the Board Paper.

Ms Borland outlined the main elements of Improving Health in Scotland : The Challenge which had been issued by the Scottish Executive to provide a strategic framework for the delivery of a more rapid rate of health improvement in Scotland. She outlined the objectives of the Challenge document which was to be the first in a series and was aimed primarily at the period to mid 2004, at which point a second phase of the framework would be published. While work was expected to continue in all determinants of health, for the first phase of the Challenge, the main focus was on the following five key risk factors affecting health:

ACTION BY

- tobacco
- alcohol
- low fruit and vegetable intake
- physical activity levels
- obesity

and working in the four following areas:

- early years
- teenage transition
- workplace (working-age people)
- communities

Work on the key themes within these four areas would be measured through the Performance Accountability Framework for health improvement. Ms Borland led the Board through examples of the extensive range of work currently underway to meet the Health Improvement Challenge in Greater Glasgow. She set this in the context of Glasgow being the most income deprived local authority area in Scotland with one-third of the worst 10% of wards for unemployment and nearly one-half of the worst 10% for health. The Board's health improvement efforts were, therefore, set firmly within the social inclusion framework.

At their meeting on 12 May, the Local Health Plan Steering Group discussed the potential to maximise some of the opportunities provided by the city's review and take a West of Scotland approach on a few key priority health issues with a view to achieving the "step change" required by the Challenge.

Smoking prevention was considered the area that would most benefit from such a focused and co-ordinated approach, particularly in achieving a situation where smoke free becomes the norm in all public places. This would require the concerted efforts of the relevant NHS Boards, local authorities and their community planning partners, as employers, service providers and policy makers in operating no smoking policies in all spheres of their activities.

Other areas of health improvement where the Steering Group considered a more focused and co-ordinated approach could make the difference were alcohol, nutrition and employment.

Councillor Collins welcomed the Challenge but highlighted a need to ensure that local priorities within different local authority areas varied. He referred back to the Chairman's commitment to meet Glasgow's MSPs quarterly and encouraged similar meetings with politicians in local authority areas who had responsibility for health and social work. Sir John welcomed this suggestion. Mr Divers confirmed that the Challenge would reflect local priorities particularly as the Local Health Plan Steering Group had input from all six of Greater Glasgow's local authority partners.

Mrs Kuenssberg welcomed the inclusion of the two areas of early years and teenage transition. She highlighted, however, the gap between the two and the importance in defining early years and teenage transition to ensure continuity of services particularly to vulnerable groups – narrowing this gap.

Mr Divers confirmed that assessment of progress within Greater Glasgow would be made prior to the NHS Board's Accountability Review meeting set for 25 June.

ACTION BY

DECIDED:

- That the main element of "Improving Health in Scotland : The Challenge" and work underway in Greater Glasgow to address this Challenge be noted.

- That the Local Health Plan Steering Group recommendation (as contained in Section 4 of the Board Paper) be approved.

61. IMPROVING MATERNITY SERVICES – THE NEXT STEPS

A report of the Director of Planning and Community Care [Board Paper No 03/32] asked the NHS Board to approve the proposed process to establish a Working Group with a remit to:

- Comprehensively review and provide advice on how to provide modern, safe and sustainable maternity delivery services for the NHS Board's population as the final stage of implementing the Maternity Services Strategy.

- Carry out its work in a fully engaging, transparent and accessible way.

The NHS Board was also asked to approve the establishment of a comprehensive effort, through the Maternity Services Liaison Committee's (MSLC's) consultation network, to engage consumer interests in maternity services to further inform its decisions.

Ms Renfrew explained that this was the final strand in implementing the Maternity Services Strategy, which was developed in partnership with women and had already achieved a number of the priorities they set for services. These included strengthened community services, innovative maternity centres, improved relationships with primary care and better information and support for pregnant women.

Ms Renfrew outlined the review of the Maternity Services Strategy which had been conducted under the auspices of the Maternity Services Liaison Committee (MSLC) in 1999. Following the MSLC report, the Board undertook a major consultation exercise in autumn 1999 and, in reviewing the outcome of the consultation in November of that year, approved a Maternity Strategy with a series of recommendations including a reduction in delivery units from three to two. In parallel to the extensive programme of public engagement around the Maternity Strategy and full consultation to debate the options for the future shape of delivery services, the Acute Service Services Review raised the question of the future siting of paediatric services – it was concluded that a combined process for paediatrics and the maternity services should be a core component of the further development of the Acute Services Strategy. By late 2001, that further development and consultation had concluded that decisions on the siting of paediatrics and the delivery component of maternity services should not form part of the overall Acute Services Review.

Ms Renfrew proposed a way in which the Board should arrive at a fully informed view on the future pattern of delivery units in advance of formal public consultation. Key aims of that process were to enable all the clinical, professional and women's interests to have their say in this important decision and to ensure that the Board was fully advised on all aspects of this matter prior to reaching conclusions. She also described the policy context, regional planning dimensions and the key clinical, service and financial issues.

ACTION BY

The Princess Royal Maternity Hospital (PRMH) at present delivered around 4,800 babies against a probable capacity of 6,500 and, therefore, had unused facilities. The Queen Mother's (QMH) and the Southern General (SGH) delivered respectively, 3,400 and 3,000 babies each year operating at around 60% of their potential capacity. Both had ageing facilities which needed capital investment to provide a modern standard of accommodation.

There were a number of important issues which needed to be considered in determining the future pattern of delivery services. The primary concern must be to achieve the highest standard of care and safety for women and their babies. This meant the need to consider carefully the relationship between maternity services and the needs of women and babies who experienced complications or problems during delivery, recognising that for the vast majority of patients, this was an uncomplicated and happy event. The NHS Board also needed to ensure that it was providing care in modern facilities, properly used, and that those services were accessible to women and their families.

The question of which delivery unit should be developed as Glasgow's second centre for the future was a complex one, with a number of clinical, patient and financial factors which needed careful evaluation. Ms Renfrew outlined the intention to ensure that before the NHS Board developed its proposals for formal consultation all of the critical issues were carefully and transparently considered in a way which enabled strong public and professional engagement. As such, the paper proposed the establishment of a small Working Group which would consider all of the available evidence and information. This would include a number of sessions, open to the public, where key interests would have the opportunity to set out their views for discussion and debate. The Working Group would be independently chaired and would include four non Executive Board Members. In addition to this Working Group it was intended to identify the consumer interests and networks around maternity services and establish a process to brief those interests and networks on the key issues. This would enable a range of patient views to be fully included in the Board's evaluation. To this end, the attachment to the Board Paper provided further detail on this approach of communication. These two important strands of work should be completed by the middle of August 2003 to enable the Board to formulate propositions and embark on formal public consultation in October 2003.

Councillor Collins referred to the contribution that could be made to the Working Group from the Women's Policy Group and the six local authority partners who would be able to assist in the process.

Mrs Kuenssberg raised concern about the timescale but was assured by Mr Divers that in aiming to embark on formal public consultation in October 2003 this afforded plenty time for all key players to contribute to the process.

Mr P Hamilton suggested the involvement of the new Public Involvement Management Committee who would be another body that could actively contribute to this.

Mrs Smith welcomed such a thorough process of public consultation which may be regarded as a template in Greater Glasgow for future consultation exercises.

DECIDED:

- That the proposed process to establish a Working Group with a remit to: **Director of Planning and Community Care**

ACTION BY

➢ Comprehensively review and provide advice on how to provide modern, safe and sustainable maternity delivery services for the NHS Board's population as the final stage of implementing the Maternity Services Strategy;

➢ Carry out its work in a fully engaging, transparent and accessible way

be approved.

- That the establishment of a comprehensive effort, through the Maternity Services Liaison Committee's (MSLCs) consultation network to engage consumer interests in maternity services to further inform its decisions be approved. **Director of Planning and Community Care**

62. WHITE PAPER – PARTNERSHIP FOR CARE

A report of the Director of Planning and Community Care and NHS Board Chief Executive [Board Paper No 03/33] was submitted asking the NHS Board to endorse:

- the proposed development process for Community Health Partnerships;
- the arrangements to begin to establish a Service Redesign Committee;
- The proposal to establish a Performance and Resources Monitoring Group.

A series of organisational changes were proposed in the White Paper to deliver a series of imperatives for the NHS in Scotland and NHS Boards were required to deliver on a number of actions including:

- Developing proposals for the transition to Community Health Partnerships (CHPs).
- Establishing a Service Redesign Committee.
- The need for cross system, unified working and clear arrangements for corporate governance, including performance management.

Each one was taken in turn.

(i) <u>Community Health Partnerships</u>

The White Paper acknowledged the progress made by Local Health Care Co-operatives (LHCCs) in developing into responsive and inclusive organisations. It proposed, therefore, their evolution into Community Health Partnerships (CHPs) with an enhanced role in service planning and delivery.

The White Paper was neither detailed nor prescriptive in its proposition about Community Health Partnerships. Reflection on the NHS Board's local context should form an important part of the debate about what it wanted to achieve in moving to CHPs. Ms Renfrew set out how this might be organised and debated by proposing three strands of activity as follows:

- Establishment of a Board Wide Steering Group, bringing together the representatives of the main interests to take responsibility for leading the development and implementation of CHPs. Membership should include LHCC representation from the professional advisory committee, key PCT staff, representatives from public health, health promotion and planning at GGNHSB and of acute and children's services.

ACTION BY

- An early event, under the auspices of the Steering Group, to bring together a range of frontline staff to contribute their thoughts at the formative stage of developing this approach.

- Early engagement with each local authority and its LHCCs to ensure they influenced and informed overall development of CHPs and, particularly, the development and implementation of the CHPs for their area. This was probably best achieved through existing joint structures.

These proposals reflected initial discussions with LHCC interests, local authorities and the Primary Care Trust – the objective was that they should enable the NHS Board to bring forward detailed proposals for the pattern, scope and organisation of CHPs by the end of 2003 enabling formal consultation in the early part of 2004. Consideration would be given to the timescales, which had been set nationally. There was a common view that additional time may be required to ensure a well developed and sustainable set of proposals. The work of the Steering Group would need to link into the wider process to consider future operational arrangements across the Glasgow NHS. It was critically important that during this development phase momentum of progress led by LHCCs and the work with local authorities was maintained.

Mr Robertson was encouraged with this direction of travel which had a very worthwhile outcome and was pleased to note that a wide range of stakeholders had been included in the process.

Mr Goudie saw an ideal opportunity to involve the acute sector at an early stage to ensure the development and full potential of CHPs was achieved.

To this end, Mr Divers suggested using the model of joint chair leadership and suggested Ian Reid and Catriona Renfrew. The process in itself was complex particularly in relation to local authority boundaries and as such it was paramount to launch it appropriately.

(ii) Service Redesign Committee

The Health White Paper included a very strong cross-cutting focus on service redesign and NHS Boards were expected to co-ordinate redesign activity by putting in place service redesign programmes and developing a Change and Innovation Plan that was specific, prioritised and resourced.

With the NHS in Greater Glasgow, there were wide ranging and significant programmes of activity which met many of the aspirations of the White Paper in that redesign and modernisation should be at the core of the delivery of healthcare.

It was proposed to establish a shadow Service Redesign Committee, chaired by a NHS Board non Executive and including membership from professional advisory structures and staff partnership arrangements. Given the plethora of redesign, change and innovation already occurring across the NHS in Greater Glasgow, it was proposed that the Shadow Committee should, in its initial phase, focus on four key areas enabling the NHS Board to sign off final proposals to establish a substantive Committee in the autumn of 2003.

ACTION BY

Over and above the membership proposed for the Service Redesign Committee, Mr Goudie suggested the inclusion of a human resource function. This was taken on board particularly in relation to an organisational development (OD) capacity that this role may bring. Furthermore, it was anticipated that the new NHS Board Medical Director would be involved in this process.

(iii) Performance and Resource Monitoring Group

Mr Divers outlined the focus on delivery of consistent, high quality care across NHS Scotland and the enhanced role for NHS Quality Improvement Scotland and Audit Scotland in monitoring the quality of clinical care and of other supporting services.

It remained the role of the NHS Board itself to define and determine key strategic and policy issues. It was proposed that the Monitoring Group carried delegated responsibility on the NHS Board's behalf for the monitoring of organisational performance and of resource allocation and utilisation.

Mr Divers outlined the key responsibilities for the Group in relation to resources and organisational performance and one potential model would see the Group meeting on a two monthly cycle.

The NHS Board Chairman would chair this Group. Potential membership of up to ten members may include a spread of non Executive interests within the NHS Board, including the Employee Director, and a spread similarly of Executive representation from the NHS Board and NHS Trusts.

In response to a suggestion from Mr Robertson, Mr Divers related the Group's relationship to the NHS Board as formal in that Group reports would be submitted to the NHS Board, all papers sent to Group Members would be sent to all NHS Board Members for information and an open invitation to all NHS Board Members to attend this Group would be standard practice.

Councillor Collins raised concern that the Group could "approve annual financial allocations and investment plans as part of the update of the Local Health Plan". It was agreed that the word 'approved' be changed to 'consider'. **Chief Executive**

Councillor Collins was reassured to note that the membership would first of all derive from those who expressed an interest.

Mrs Kuenssberg welcomed the formation of such a Committee which linked strategy and action at NHS Board level.

Ms Crocket recognised the status of the Group in terms of the business it was expected to undertake and suggested that the Clinical Governance Committee also link in.

DECIDED:

1. The proposed development process for Community Health Partnerships be endorsed. **Director of Planning & Community Care**

ACTION BY

2. The arrangements to begin to establish a Service Redesign Committee be endorsed. **Director of Planning & Community Care**

3. The proposal to establish a Performance and Resources Monitoring Group be endorsed. **Chief Executive**

63. GENERIC INCIDENT MANAGEMENT/OUTBREAK CONTROL PLAN

A report of the Director of Public Health [Board Paper No 03/34] asked the Board to note the Generic Incident Management/Outbreak Control Plan.

Dr Burns welcomed Dr Ahmed, Consultant in Public Health Medicine, who explained that the Plan had been developed to form the basis of the NHS Board's response to incidents and outbreaks irrespective of source (deliberate or accidental). It formed part of the overall NHS Board's response to major incidents and should be read in conjunction with the NHS Board's Major Incident Plan and the Communications Strategy.

The Plan had been developed by Greater Glasgow NHS Board in consultation with its local authority environmental health departments following Scottish Executive guidelines issued in February 2003.

It aimed to provide a framework for the management of a co-ordinated response to any incident or outbreak within the NHS Board's area in order to protect the health of the public and outlined the actions to be taken by the NHS Board, local authority environmental health departments and other agencies in the event of suspected or actual incident or outbreak with potential public health implications.

Dr Ahmed advised that Greater Glasgow NHS Board was the lead agency in co-ordinating incidents and as such the communication about risk as well as advice was vital.

Dr Burns referred to the fine balance between communicating to the population to protect the public health and the legal and ethical responsibilities of the NHS to protect patient privacy. It was paramount to balance the two imperatives and this message would be taken forward with key interested parties and hopefully the media.

In response to a question from Councillor Collins, Dr Ahmed confirmed that the draft plan would go out to all Greater Glasgow's local authority partners for approval.

NOTED

64. ACCOUNTABILITY REVIEW 2002/03 : YEAR END UP-DATE OF PROGRESS

A report of the Chief Executive [Board Paper No 03/35] asked the Board to receive the year end up-date of progress in taking forward the priorities agreed at the 2002 Accountability Review Meeting with the Scottish Executive Health Department and note the arrangements for the 2003 Accountability Review Meeting which was to be held on 25 June 2003.

Mr Divers set out the six key action points agreed at the conclusion of the Accountability Review Meeting in June 2002 and provided a year-end up-date of progress ahead of the 2003 Accountability Review Meeting scheduled for 25 June 2003. The six key action points were:

ACTION BY

- Managing within available resources
- Managing the Capital Programme to sustain implementation of the Acute Services Review
- Delivering the targets for waiting times
- Maintaining Progress on Developing the Beatson Oncology Centre
- Working to reduce the incidence of health care acquired infection
- Developing the staff governance agenda

The format of the Accountability Review Meeting would be based on a plenary meeting between NHS Board and Trust Chairs and Chief Executives and the Health Department's Senior Team, preceded by a discussion with members of the Area Partnership Forum. In addition, there would be a meeting with representatives of the Area Clinical Forum as part of this year's process. A full report on the outcome of the Review, with the agreed Action Plan, would be brought to the NHS Board at its August 2003 meeting.

DECIDED:

- The year-end up-date of progress in taking forward the priorities agreed at the 2002 Accountability Review Meeting with the Scottish Executive Health Department be received.

- That the arrangements for the 2003 Accountability Review Meeting scheduled for 25 June 2003 be noted.

65. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/36] noted progress towards delivering the NHS Board's agreed over nine month waiting time reduction.

Ms Renfrew explained that there was no longer a deferred waiting list and that all patients were now on a unified list which was made up of two categories:

- Patients without Availability Status Codes (ASCs)
- Patients with ASCs

The Availability Status Code removed the concept of guarantees and associated exceptions and replaced them with codes that described availability for treatment. Each patient whose circumstances prevented them from receiving an offer of admission for the specialty or procedure would have an ASC code applied. In terms NHS Greater Glasgow, there were 20,967 inpatient/day case patients waiting as at 30 April 2003. Of this, 667 patients were waiting over nine months at the end of April with no ASC code applied – it was planned to reduce this to zero by 31 December 2003.

Planning processes were in place to ensure that the NHS Board continued to move towards:

- Maximum wait for inpatient and day case treatment of 9 months by December 2003.

ACTION BY

- Maximum wait for inpatient and day case treatment of 6 months by December 2005.

- Maximum wait for outpatient appointments of 26 weeks by December 2005.

In response to a question from Mr P Hamilton, Mr Calderwood advised that work was ongoing to clear waiting lists in an attempt to treat patients with equal priority. Mr Davison advised that two specialties provided the longest waiting times, that of Orthopaedics and Plastic Surgery. It was agreed that future reports differentiate between the different ASC codes to provide further information. **Director of Planning and Community Care**

NOTED

66. REFORMING THE NHS COMPLAINTS PROCEDURE : PATIENT FOCUS AND PUBLIC INVOLVEMENT - CONSULTATION

A report of the Head of Board Administration [Board Paper No 03/37] asked the NHS Board to note a tabled paper detailing the responses received to the consultation on the Complaints Procedure.

The consultation period ended on 2 June 2003 and a seminar had been held on 15 May 2003 in order that the proposals within the consultation document could be presented and feedback received from all NHS Greater Glasgow key complaints personnel.

Mr J Hamilton led the Board through the main outcomes deriving from the seminar which would form part of the Board's overall response to the consultation document. He encouraged any Board Member to feed in further comments to him for inclusion in this response. **Head of Board Administration**

NOTED

67. NHS GREATER GLASGOW AUDIT COMMITTEE - MEMBERSHIP

A report of the Head of Board Administration [Board Paper No 03/38] asked the Board to note the revision in the membership of the NHS Greater Glasgow Audit Committee and agree the two revisions to the Composition of the Committee.

DECIDED:

- That the Constitution, in relation to the appointment of a Convener, be amended to read: **Head of Board Administration**

  "The Convener will be appointed from the membership of the Committee"

- That the revision in the membership of the NHS Greater Glasgow Audit Committee be noted. **Head of Board Administration**

- That the two revisions to the Composition of the Committee be agreed. **Head of Board Administration**

ACTION BY

68. MINUTES OF THE MEETING OF THE GREATER GLASGOW NHS BOARD HEALTH AND CLINICAL GOVERNANCE COMMITTEE

The Minutes of the meeting of the Greater Glasgow NHS Board Health and Clinical Governance Committee [GGNHSB(HCGC)(M)03/2] held on 6 May 2003 were noted.

The meeting ended at 12.15 pm

GGNHSB(M)03/6
Minutes: 69 - 83

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Board Room, Dalian House,
350 St Vincent Street, Glasgow
on Tuesday 17 June 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Best	Professor M Farthing
Mr R Calderwood	Councillor J Handibode
Councillor D Collins	Mrs W Hull
Ms R Crocket	Mrs S Kuenssberg CBE
Mr T Davison	Mrs R K Nijjar
Mr T A Divers OBE	Dr J Nugent
Councillor R Duncan	Mr I Reid
Mr W Goudie	Mr A O Robertson OBE

Mrs E Smith

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

Ms E Borland	Acting Director of Health Promotion
Councillor J Coleman	Glasgow City Council
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Planning and Community Care
Professor A Rodger	Medical Director, Beatson Oncology Centre (for Minute No 76)
Mr J Whyteside	Public Affairs Manager

B Y I N V I T A T I O N

Dr F Angell	Chair, Area Dental Committee
Mr J Cassidy	Chair, Area Nursing and Midwifery Committee
Ms G Leslie	Chair, Area Optometric Committee
Mr J McMeekin	Vice Convener, Greater Glasgow Health Council
Mrs F Needleman	Chair, Area Pharmaceutical Committee
Mr H Smith	Chair, Area Allied Health Professionals Committee
Dr B West	Chair, Area Medical Committee

ACTION BY

69. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr H Burns, Mr R Cleland, Mr P Hamilton, Mrs P Bryson (Convener, Greater Glasgow Health Council).

ACTION BY

The Chairman welcomed Councillor Coleman, representing Glasgow City Council (replacing Councillor John Gray) to the meeting. Ratifications to NHS Board membership to be announced shortly by the Minister for Health and Community Care were:

Frank Angell – as Chair of the Area Clinical Forum
Brian Cowan – as the Medical Director

Following these ratifications, the NHS Board membership would total twenty-five Members.

In terms of local authority representation, the following had been confirmed:

Glasgow City Council – Councillor Jim Coleman
East Dunbartonshire Council – Councillor Robert Duncan
East Renfrewshire Council – Councillor Danny Collins
South Lanarkshire Council – Councillor Jim Handibode
West Dunbartonshire Council – local nomination process to be completed by end of June

NOTED

70. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

(a) Attendance on 28 May at a meeting with senior officers from the Scottish Executive Health Department Public Appointments Unit. This was to discuss the task which lay ahead in appointing Non Executive Members to the NHS Board.

(b) Attendance on 28 May at a meeting of the City Region Partnership at the City Chambers. This was an important meeting and would be followed up on a city basis as well as a regional basis.

(c) Met the Monitoring Group Chairs (established by the Minister for Health and Community Care to oversee the continuation of "named" inpatient services at Stobhill Hospital and the Victoria Infirmary prior to the implementation of the major strategic change which was planned later in this decade) on 28 May 2003. Both Ian Miller (North) and Peter Mullen (South) had held their first respective Monitoring Group meetings and would continue to brief the Chairman on ongoing developments.

(d) Attended a working dinner at the Principal's Lodge, University of Glasgow, on 29 May to discuss the Glasgow Centre for Population Health. This was now being taken forward by an external Advisory Group and the Chairman would send a letter to the Minister of Health and Community Care regarding the course of action to be taken in connection with its implementation in Glasgow.

NOTED

ACTION BY

71. CHIEF EXECUTIVE'S UPDATE

Mr Divers updated on the following developments since the last NHS Board meeting:

(a) In terms of the ongoing City Partnership working, Mr Divers was taking forward the elements relating to Community Planning.

(b) Bill Goudie (Employee Director) and Mr Divers had arranged a further facilitated half-day seminar with the Area Partnership Forum looking at the staff governance strategy and how it might develop to take account of the White Paper – Partnership For Care.

(c) A meeting had taken place on Monday 16 June 2003 at which he, Bill Goudie and three full-time union officials met with other senior NHS Greater Glasgow staff to take forward discussion regarding the "Soft FM" services within the public/private agreement associated with the implementation of the acute services strategy. Key actions points had been agreed and discussions would continue as the procurement process proceeded.

NOTED

72. MINUTES

On the motion of Mr A O Robertson, seconded by Councillor D Collins, the Minutes of the meeting of the NHS Board held on Tuesday 20 May 2003 [GGNHSB(M)03/5] were approved as an accurate record and signed by the Chairman pending the following amendment:

- Councillor J Handibode's name to be deleted from those present.
- Ms Pat Bryson's name added to those present

73. MATTERS ARISING

Members were circulated with the rolling action list which updated on the progress and timescale for ongoing matters arising. In terms of specific action, the following was reported:

(a) The Chairman had written to Councillor John Gray thanking him for his valuable contribution to the work of the NHS Board.

(b) Professor Margaret Reid had agreed to act as Independent Chair of the Working Group looking at the open process of assessment regarding Greater Glasgow's Maternity Services. Non Executive Members who had also agreed to form part of this Working Group were:

Peter Hamilton
Ros Crocket
Professor M Farthing

The Group would benefit from the input of professional advisers in relevant areas to the evaluation of Maternity Services. A first meeting of the Group was scheduled for the afternoon of Tuesday 17 June 2003 when Professor Reid and Members would agree their modus operandi.

ACTION BY

The Director of Corporate Communications would make available to the Press background information about Professor Reid and the Working Group members. **Director of Corporate Communications**

NOTED

74. LOCAL HEALTH PLAN

(a) Final Update 2003/04

A report of the Director of Planning and Community Care [Board Paper No 03/39a] asked the NHS Board to approve the final update of the Local Health Plan.

Sir John referred to the new financial strategy which was now in place to ensure that pressures could be met without affecting the long-term objectives of the Local Health Plan. In total, the NHS system would invest £1.2 billion this financial year while almost £7M of Health Plan developments in this year's plan had been re-phased or reconsidered for year two and beyond. Affected were aspects of developments in Mental Health, Child and Maternal Health, Acute and Primary Care and Community Services. Nonetheless, the NHS Board remained committed to its developing Local Health Plan and recognised that continuity of commitment to the people of Greater Glasgow in areas of recognised need was paramount. This often involved major partners. Financial pressures would be felt in some newer priority areas where the commitment to future funding had to be secure before these could be initiated.

Ms Renfrew outlined the purpose of the Local Health Plan which set a strategic direction for the next five years but focused in detail on 2002/03. The updated version of the plan retained a similar strategic direction but included more detailed plans and priorities for 2003/04 and an indication of progress in the past year.

The content of the Local Health Plan was a product of a whole range of different planning processes which included local authorities, NHS staff and other stakeholders. Much of that detailed planning had also included significant public engagement and it was intended that the document would provide an overview and sign posting to detailed plans. A summary for general readers would also be produced.

Over the past five months, the draft update of the Local Health Plan had been widely discussed and Ms Renfrew set out the main areas of change resulting from the discussion at the December 2002 NHS Board meeting. The most significant change since December 2002 was the reduction in the availability of new resources.

The consequences for the Local Health Plan were reflected in the update taking cognisance of the strong Scottish Executive Health Department focus on the twelve national priorities. Although the updated Local Health Plan focused on delivering these priorities, this would be particularly challenging within the resources the NHS Board had been able to allocate. The plan, therefore, highlighted those pressure points and associated risks. Ms Renfrew commented on new sections added to the Local Health Plan including:

ACTION BY

- A contribution from each of Greater Glasgow's NHS Trusts setting out in more detail the contribution of NHS Trusts to the delivery of strategic themes and priorities in the Local Health Plan (Section 8 of the Local Health Plan).

- Public involvement (Section 7.10 in the Local Health Plan).

- Working with local authorities as NHS Greater Glasgow's most important planning partners (Section 4 of the Local Health Plan).

Finalising the plan had been challenging with the revised financial assumption. Early and comprehensive process and progress on revisiting the Financial Strategy, which was such a critical element of the Local Health Plan, would be important to delivering a coherent update to the plan for 2004/05.

In response to a question from Councillor Collins, Mr Divers advised that the Local Health Plan Steering Group meeting on Monday 16 June 2003 had the six local authorities present and they had the opportunity to consider further the final draft and offer any final editing by the end of the month.

Mr I Reid suggested that the document be widely shared with staff in particular, as last years staff survey had shown that staff had little or no knowledge of the Local Health Plan. It was agreed that the plan be widely circulated via the four NHS Trusts and Partnership Forum. Ms Renfrew also commended the staff newsletter produced by the Corporate Communications Team at the NHS Board – this was widely circulated and briefed staff on elements of the Local Health Plan.

Director of Planning and Community Care

Referring to the costs of implementing the Mental Health Act (as discussed on page 25 of the Board Papers) Dr Nugent sought clarity around the cost associated with this. Ms Renfrew explained that the associated costs were mainly in the administrative processes and Psychiatric time. The Scottish Executive had commissioned an independent evaluation of likely costs to NHS Boards and Greater Glasgow Primary Care NHS Trust was due to be visited by a member of this Evaluation Group to have an assessment undertaken in relation to supporting the implications of this Act.

DECIDED:

That the final update of the Local Health Plan be approved, subject to some final editing.

Director of Planning and Community Care

(b) Revenue Planning 2003/04 and Financial Strategy 2003/04

A report of the Chief Executive [Board Paper No 03/39b] was submitted finalising allocations and a financial plan for 2003/04.

Mr Divers highlighted the three key objectives in taking forward the update of the Local Health Plan:

- To continue the major task involving a two-year approach started last year to return the acute sector Trusts to recurrent balance.

ACTION BY

- To maintain the commitment to invest across all care programmes set out in the existing Local Health Plan.

- To position the NHS Board to build up, from 2004/05, the revenue which was required to fund implementation of the Board's Acute Services Plan, the local Forensic Psychiatric Unit and other key strategies.

The overall objective of the in-year financial strategy was to ensure break-even. Given the challenges inherent in Trusts' start-points, it would be essential that the monthly financial performance was closely monitored. The timing of the review of the Financial Plan for future years needed, therefore, to be carefully co-ordinated with any issues that may arise from the emerging in-year position.

Mr Divers outlined the time and effort spent in over-hauling the investments which it was initially hoped the Revenue Plan would be able to support in 2003/04. The outcome of this had brought about a reduction in the planned expenditure across the four major programmes (Mental Health, Child and Maternal Health, Acute and Primary Care and Community Services) of almost £7M in 2003/04.

Mr Divers summarised why it had been necessary to review the Financial Plan and referred to a number of changes that had occurred including:

- Instead of prescribing costs increasing by the forecast 10% or less, new and more expensive products saw costs rise by 12% or 13%.

- Glasgow's dwindling population had affected the Board's Arbuthnott Formula status – the system used to calculate Greater Glasgow's share of national allocation. The NHS Board moved from being a "gaining" Board in the last three years to being a "losing" Board in the current financial year.

- The cost of pay and pay related inflation (including significantly higher national insurance costs this year) were ahead of those planned for in the financial framework.

- The impact of the junior doctors' "New Deal" agreement was several million of pounds higher than the early years' estimates.

Mr Davison outlined the important work going on in redesigning the clinical workforce by looking at junior doctors' compliance with the "New Deal". He explained the fragile situation particularly in monitoring compliance of these rotas which was very rigid. Three phases of work were ongoing to address the implications of the "New Deal" agreement:

(i) A Steering Group had been established.

(ii) External advisers had been commissioned.

(iii) A Project Team had been recruited.

ACTION BY

The key issue was in deploying staff more efficiently and not in reducing costs as such, there were links between this work and workforce planning (being led by Ian Reid). Mr Davison advised that the next meeting of the Steering Group was to take place in the afternoon of Tuesday 17 June 2003 and he would keep the NHS Board advised of future developments.

In connection with the GP prescribing, Dr Iain Wallace (Medical Director, Greater Glasgow Primary Care NHS Trust), had formed a Group with the specific remit of looking at the implications of this. As the workings of this group progressed, it was suggested that Dr Wallace attend a future NHS Board meeting to update on the work of this Group.

NOTED

(c) 2003/04 Revenue Startpoints

A report of the Director of Finance [Board Paper No 03/39c] asked the NHS Board to:

- Note the complexities of the 2003/04 and beyond revenue position for NHS Greater Glasgow.

- Agree that for 2003/04 the Board should deploy the totality of the resources available to it in order to meet startpoint revenue allocations and the reduced commitments on all programme proposals, mindful of the need to continue to validate ongoing investments in-year.

- Recognise the challenge in these startpoints and in the programme investments and agree that the Performance and Resources Monitoring Group monitors in-year performance rigorously to ensure that financial break-even for the year was achieved.

- Remit to the Performance and Resources Monitoring Group, the task of overseeing the review of the entire financial plan for future years with this work beginning in August 2003.

Mrs Hull commented that progress in agreeing both startpoint allocations and new investment plans for 2003/04 had been complex and challenging. The "first cut" analysis discussed by the Board on 4 March 2003, confirmed the new monies available to NHS Greater Glasgow in 2003/04 as £67.4M. This differed from that expected by £11.1M as a result of:

- £7M – change in Arbuthnott reflecting reduction in population identified by the census, whereby NHS Greater Glasgow was no longer a "gaining" Board.

- £4.1M – no additional funding for increased National Insurance Contributions.

Mrs Hull led the Board through the summary of the 2003/04 revenue position and the eight recommended points, particularly in relation to prioritising investment decisions, the availability of non recurring funding and other programme proposals.

ACTION BY

In response to a question from Mr Robertson, Mrs Hull agreed to tease out the £8.90M described as "other" at step one on page 43 of the Board papers. The Performance and Resource Monitoring Group would be established as quickly as possible so that it oversaw the NHS Board's revenue and capital planning processes and decision-making. **Director of Finance**

Mr Best recognised the difficulties and challenges but praised staff who were providing ongoing care, balancing work in recognition of national and financial priorities.

Mr Goudie expressed his disappointment at the Government's continual announcements of new initiatives which had cost implications to NHS Boards and raised expectations of staff and members of the public. Such messages were not helpful to the NHS Board in working to meet the needs of its population within budgetary constraints.

It was recognized that this was a difficult year, however, a significant number of new investments would be supported. The NHS Board's Communications Strategy was improving significantly and many initiatives around patient focus and public involvement were being developed.

DECIDED:

- That the complexities of the 2003/04 and beyond revenue position for NHS Greater Glasgow be noted.

- That for 2003/04 the Board deploy the totality of the resources available to it in order to meet startpoint allocations and the reduced commitments on all programme proposals, mindful of the need to continue to validate ongoing investments in-year be agreed. **Director of Finance**

- That the challenge in these startpoints and in the programme investments be recognised and that the Performance and Resources Monitoring Group monitors in-year performance rigorously to ensure that financial break-even for the year was achieved be agreed. **Director of Finance**

- That the Performance and Resources Monitoring Group be tasked with overseeing the review of the entire financial plan for future years, with this work beginning in August 2003. **Director of Finance**

75. ACUTE SERVICES REVIEW – PROGRESS : QUARTERLY REPORT

A report of the Chief Executive, GGNHSB and Chief Executive, South Glasgow University Hospitals NHS Trust [Board Paper No 03/40] asked the NHS Board to receive the quarterly update of progress in taking forward key aspects of the Acute Services Plan.

Mr Divers referred to the terms of reference of Audit Scotland who were responsible for monitoring and reporting annually on:

- The overall governance and project management processes adopted by the NHS Board.

- The NHS Board's arrangements for updating the key planning assumptions and the high level capital and revenue estimates.

ACTION BY

- The arrangements for effective consultation with stakeholders.

The detailed audit would be conducted by PricewaterhouseCoopers, the NHS Board's external auditors and over recent weeks, the external auditors had been developing their plans for taking forward this responsibility. Given the early stages of the implementation, PricewaterhouseCoopers proposed to commence the next part of their review during late August 2003, with the aim of providing a formal report by late October/early November 2003. That report would, therefore, come to the NHS Board at its November meeting.

To support the NHS Board's governance role in taking this strategy forward, a Project Executive Group was established, chaired by the NHS Board Chief Executive. It involved all five NHS Greater Glasgow Chief Executives, other senior Executive colleagues within NHS Greater Glasgow, in addition to staff partnership input and input from the Scottish Executive Health Department. This Group was charged with overall responsibility for progressing the implementation of the review and was the key link with the NHS Board and the Programme Director, Mr Robert Calderwood.

Ms Renfrew and Dr Brian Cowan (Medical Director, South Glasgow University Hospitals NHS Trust) were jointly leading the Services/Beds and Capacity Subgroup. Reflecting the importance of clinical engagement in this work, the Board was establishing a Pan Glasgow Clinical Board, with Trust and Advisory Committee membership to provide a strong clinical overview across the Subgroup's work. In addition, for each of the key specialties, there would be created a small clinical group to participate in the capacity modeling and for those specialties where there were still disposition issues to resolve there would be a more extended clinical engagement to consider the key issues.

Mr Calderwood led the Board through various blocks of work put in place to oversee the Acute Services Review. Reporting to the Project Executive Group were financial advisers, legal advisers, Trust advisers and technical advisers. The overall review had been divided into eight key areas as follows:

Ambulatory Care Hospitals (ACADs)	Financial Planning
Community Engagement	Workforce Planning
Communication	Clinical Groups
Transport and Accessibility	Services/Beds/Activity

A senior officer had been nominated to lead each area and working groups established to take forward the agenda under each heading.

The next stage would be to establish a core central team to link together the work of all teams into a coherent management programme. All strands of work would be reported back to the NHS Board.

ACTION BY

In relation to the expectation of single system working, Councillor Collins and Mr Robertson both raised the point about dedicated time and skills of the Project Executive Group. Mr Calderwood confirmed that the balance and range of skills of the current Group sat appropriately with the positioning and status of the Acute Services Review. There was a strategic balance in the Group particularly given that the Chief Executives were committed to pan Glasgow working – given this, the Group was sensitive to striking a balance as new strategic issues emerged. The Group's work would evolve through time and the exact arrangements would be kept under review. In addition, Mr Robertson encouraged the Project Executive Group to build on the very positive working that had taken place with Glasgow City Council and Strathclyde Passenger Transport particularly in relation to developments on the Gartnavel Hospital site.

Sir John appreciated that progress was in a transitional state at the moment but was certain that the complex issues to be addressed would be done so with the key players involved.

In response to a question from Mr Goudie, Mr Divers confirmed that Audit Scotland would also comment on the Services/Beds and Capacity issues.

Mrs Smith was heartened to see the transition from the consultation and debate to an action plan and the involvement of the Project Executive Group which demonstrated pan Glasgow working. She hoped the NHS Board would support the Trusts in as many ways as possible particularly given that key staff had been seconded to ensuring the success of the overall project. This was agreed.

Professor Farthing sought the involvement of Glasgow's Universities who could formally contribute particularly in areas of new teaching methods and research. **Programme Director**

In response to a question from Mrs Nijjar, Ms Renfrew confirmed that all communities would be involved in influencing the shape of recruitment to the community engagement teams and that she would share the protocols with her. **Director of Planning and Community Care**

Dr Nugent commended the community engagement process particularly in trying to maximise patient gain possibly through influencing service design or by addressing issues that arose as a result of proposed service change.

DECIDED:

That the quarterly update of progress in taking forward key aspects of the Acute Services Plan be received and noted.

76. BEATSON ONCOLOGY CENTRE – UPDATE OF ACTION PLAN

A report of the Chief Executive, GGNHSB and Medical Director, Beatson Oncology Centre [Board Paper No 03/41] asked the NHS Board to receive the update of progress in implementing the action plan and authorise the production of one further update to the NHS Board in Autumn 2003.

Sir John welcomed Professor Alan Rodger who had been appointed Medical Director, Beatson Oncology Centre.

Professor Rodger had been in post for two weeks and began by commending the sterling role carried out by his predecessor, Dr Adam Bryson, who had been seconded as Medical Director to the Beatson Oncology Centre.

ACTION BY

Professor Rodger described the approach he was taking both towards recruitment of Consultant Oncologists and Therapy Radiographers as well as other material areas of workforce development within the Beatson Oncology Centre.

The two staff groups under most pressure were the Clinical Oncologists and Therapy Radiographers although both had increased staffing levels compared to March 2002. In particular, Professor Rodger was pleased to announce the recent appointment of ten Therapy Radiographers though he recognized that there still remained a significant number of unfilled vacancies.

One method being explored further was the extension of the retraining programme for Radiographers run by the Beatson Oncology Centre which encouraged those who had not worked in the field for sometime to return to work following a retraining programme. The results from this had been very encouraging.

Professor Rodger had already visited three NHS Boards associated with the West of Scotland Plan to discuss logistically how the strategy for specialist oncology services could be taken forward.

Mr Divers referred to Annex 1 (pages 52 to 54 of the Board papers) and Annex 2 (pages 55 to 59 of the Board papers) which provided the NHS Board with a formal update of action taken as a result of the recommendations made by the Expert Advisory Group. The key elements within both the summary action plan and the more detailed Expert Advisory Group report had now substantially been addressed. The material outstanding recommendation from the Expert Advisory Group report, which related to the head count of Consultant Clinical Oncologists, was a key focus of Professor Rodger's strategy in the coming months. As the NHS Board developed its plan for implementation of the "Partnership for Care" White Paper, the opportunity should be taken, during the Autumn of 2003, to determine whether sufficient progress had been made against the five pre-determined criteria to give the NHS Board the confidence that it should ask the Minister for Health and Community Care to consider returning the full management responsibility for the Beatson Oncology Centre to the North Glasgow University Hospitals NHS Trust.

In response to a question from Dr J Nugent, Professor Rodger confirmed that, at present, there were 16.2 Consultant Clinical Oncologists and 3 locums in post. No patients were being turned away for treatment and treatment capacity was increasing. Waiting lists were not a crucial issue at the moment – patients being referred to the Beatson Oncology Centre were being seen there and not being referred elsewhere.

DECIDED:

- That the update of progress in implementing the action plan be received.

- That production of one further update to the NHS Board in Autumn 2003 be authorised. **Chief Executive/Medical Director, Beatson Oncology Centre**

ACTION BY

77. INTEGRATED ADDICTION SERVICES : OUTCOME OF CONSULTATION

A report of the Director of Planning and Community Care [Board Paper No 03/42] asked the NHS Board to approve proposals to move to an integrated structure for the delivery of addiction services within Glasgow City Council.

Ms Renfrew reported on the work undertaken to develop addiction services and on how integrated management arrangements could be progressed. She described the development work, the consultation which followed it and proposals to deliver integrated services and structures in terms of benefits for individual patients and organisational objectives and imperatives.

Responses to the consultation indicated that the broad aims were understood and accepted but a number of issues had been raised. These issues had been looked at in detail with thought given to the proposed way forward and next steps to address them. One final significant issue was the need to work with the NHS Board's other local authorities to agree how a similar approach for their areas could be delivered. Integrated community addiction teams with other local authorities had already been agreed but this platform needed to be built upon.

The proposals offered the opportunity to:

- Deliver better services for people with addiction problems.
- Meet national and local imperatives and commitments on service integration.
- Provide stronger local accountability for addiction services.

Further detailed implementation would be led by a joint general manager who would be appointed during the summer of 2003.

Dr F Angell, in noting that the Area Dental Committee had been consulted, was disappointed to note there was no mention of dentistry, particularly the methadone programme and the effect this had on oral health. Ms Renfrew advised that the addictions team was looking at other ways to tackle this but for the purposes of the paper it was a strategic and not operational document at this stage.

In response to a question from Mrs Nijjar, Ms Renfrew confirmed that support had been received from voluntary organisations throughout Greater Glasgow.

Mr Goudie sought further information on the concept of a single key worker and Ms Renfrew confirmed that this point was still being discussed on how best this could be achieved albeit that the broad principle had been accepted.

Dr Nugent drew attention to the key links with GP practices and commended the success so far of the pilot community addiction teams (CATs) who were working with local GP practices. He hoped this pilot would be rolled out to encourage the engagement of all Greater Glasgow's GPs at a practical level.

DECIDED:

That the proposals to move to an integrated structure for the delivery of addition services with Glasgow City Council be approved. **Director of Planning and Community Care**

ACTION BY

78. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/43] noted progress towards delivering the NHS Board's agreed over nine month waiting time reduction.

There were currently 873 patients waiting over 9 months at the end of May 2003 with no Availability Status Code (ASC) applied – it was planned to reduce this to zero by 31 December 2003.

It was intended that a detailed report would be presented to the NHS Board in future providing additional information to differentiate between the availability status codes. **Director of Planning and Community Care**

NOTED

79. QUARTERLY REPORTS ON COMPLAINTS : JANUARY – MARCH 2003

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No 03/44] asked the Board to note the quarterly report on complaints in Greater Glasgow for the period 1 January to 31 March 2003.

The Head of Board Administration commended the work undertaken by the North and South Trust who had responded to 84% and 75% respectively of their complaints received within 20 working days of receipt.

The Head of Board Administration confirmed that the Chairman had responded to the Scottish Executive Health Department consultation document on reforming the NHS Complaints Procedure. The outcome of the consultation exercise was awaited.

NOTED

80. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 03/45] was submitted seeking approval of four medical practitioners employed by the Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Rachel Brown
Dr Sheena Jones
Dr Kartini Nor
Dr Douglas Paterson

81. NOTES OF THE MEETING OF THE AUDIT COMMITTEE

The notes of the meeting of the Audit Committee [A(M)03/2] held on 29 April 2003 were noted.

ACTION BY

82. MINUTES OF THE STAFF GOVERNANCE COMMITTEE

The Minutes of the meeting of the Staff Governance Committee [GGNHSB SGC(M)03/1] held on Wednesday 23 April 2003 were noted.

Mr Goudie referred to the progress made since the Accountability Review meeting in 2002 when staff had indicated they were unhappy at the lack of involvement in strategic thinking and decision making and the need to avoid duplication of effort in taking forward key sections of partnership working.

The Area Partnership Forum was influencing strategic issues and the Staff Governance Committee was monitoring progress towards meeting the Staff Governance standard, utilizing the joint action plans developed from the staff survey and self assessment tool.

The Staff Governance Committee would consider a comprehensive report at its next meeting in connection with the implementation of PIN Guidelines and identifying factors of difficulty in their implementation. Work was being undertaken looking at a mapping exercise (led by the Head of Board Administration) of all Committees/Groups covering all of NHS Greater Glasgow's activities and how staff could be better informed and their input sought.

The completion and monitoring of the totality of the performance assessment framework (PAF) lay with the soon to be formed Performance and Resources Monitoring Group and this work would be co-ordinated by David Walker (Assistant Director for Planning and Community Care)

In reporting to the Accountability Review meeting on 25 June 2003, Mr Goudie had more positive developments to report and a clear direction of travel.

NOTED

83. MINUTES OF THE AREA CLINICAL FORUM

The Minutes of the meeting of the Area Clinical Forum held on Monday 12 May 2003 were noted.

The meeting ended at 12.05 pm

GGNHSB(M)03/9
Minutes: 109 - 121

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 0YZ on Tuesday, 16 September 2003 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell	Professor Michael Farthing
Mr J Best	Mr W Goudie
Dr H Burns	Mr P Hamilton
Mr R Calderwood	Councillor J Handibode
Mr R Cleland	Mrs S Kuenssberg CBE
Councillor D Collins	Mrs R K Nijjar
Dr B Cowan	Dr J Nugent
Ms R Crocket	Mr I Reid
Mr T Davison	Mr A O Robertson OBE
Mr T A Divers OBE (to Item 115)	Mrs E Smith
Councillor R Duncan	Councillor A White

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

Ms E Borland	..	Director of Health Promotion
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Ms C Renfrew	..	Director of Planning and Community Care
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Mr J Cassidy	..	Chair, Area Nursing and Midwifery Committee
Ms G Leslie	..	Chair, Area Optometric Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

109. APOLOGIES

Apologies for absence were intimated on behalf of Councillor J Coleman; Mrs W Hull; Mrs F Needleman, Chair, Area Pharmaceutical Committee; and Mr H Smith, Chair, Area Allied Health Professionals Committee.

110. CHAIRMAN'S REPORT

The Chairman intimated that this would be Professor Michael Farthing, Executive Dean of the Faculty of Medicine, University of Glasgow's last meeting of the NHS Board before taking up his new appointment as Principal, St George's Medical School, University of London. He thanked Professor Farthing for his contribution to the workings of the Board and Chairmanship of the Health and Clinical Governance Committee and Research Ethics Governance Committee and wished him well in his new appointment.

In reply, Professor Farthing stated how much he had enjoyed his involvement with the working of the NHS Board and wished the Chairman and Members well for the challenges that it faced over the coming years.

The Chairman welcomed Cllr. Andrew White, Council Leader, West Dunbartonshire Council, to his first meeting of the NHS Board and hoped he found his role as a Non-Executive Director both interesting and rewarding.

111. CHIEF EXECUTIVE'S REPORT

Mr Divers made reference to the following issues:-

(i) An additional NHS Board meeting was being held at 10.30 a.m. on Tuesday, 7 October 2003 in the Community Central Hall, 304 Maryhill Road, Glasgow G20 7YE, to hear three Reports on Maternity Services:

- Report of the Maternity Working Group on the Future of Maternity Services in Greater Glasgow
- Report of the Midwives Forum
- Report from Glasgow's Maternity User Representation Group.

The normal monthly NHS Board meeting would be held at 9.30 a.m. on Tuesday, 21 October, also in the Community Central Hall, 304 Maryhill Road, Glasgow G20 7YE, and it would consider a consultation document on the Future of Maternity Services in Glasgow.

(ii) A meeting had been held with the Chief Executive and Director of Social Work for South Lanarkshire Council to discuss Community Health Partnerships. Sir John Arbuthnott, Tom Divers and Catriona Renfrew had attended and further meetings had been planned with other Local Authorities – namely, East Dunbartonshire, East Renfrewshire and West Dunbartonshire.

(iii) Mr Divers had been accompanied by Robert Calderwood, Tim Davison and Catriona Renfrew to a meeting with Argyll and Clyde NHS Board officers. This was part of a regular series of meetings to discuss issues of common interest. The recent meeting had considered Maternity Services, Mental Health Services, Adult Acute Services, Cancer Network and the development of Community Health Partnerships.

112. MINUTES

On the motion of Mr A O Robertson, seconded by Mrs S Kuenssberg, the Minutes of the meeting of the NHS Board held on Tuesday, 19 August 2003 [GGNHSB(M)03/08] were approved as an accurate record and signed by the Chairman, subject to the following amendments:-

Minute 98 – Chairman's Report – (a) 5th line

Delete: "The Chairman also reported that a new Principal was now in place at the University of Glasgow ……."

Insert: "The Chairman also reported that the new Principal would take up his post on 1 October 2003 at the University of Glasgow ……."

Minute 102 – White Paper: Partnership For Care – Consultation Proposals (iv) Developing Community Health Partnerships – Page 7:1 Access

Add: "enable patients to move more readily to their home or care in a community setting".

113. MATTERS ARISING FROM THE MINUTES

Members were circulated with the rolling action list which updated on the progress and timescale of the outstanding matters. In particular -

Minute 102 – White Paper: Partnership For Care – Consultation Proposals.

Ally McLaws reported that the consultation documentation and the summary version had now been sent out to the list of consultees and the Involving People list.

Mr McLaws also reported that the Annual Report was now being prepared together with arrangements for an AGM. The distribution of the Annual Report would include distribution in a local daily newspaper, together with distribution to a variety of outlets as part of the Health News.

114. SERVICE RE-DESIGN COMMITTEE - PROPOSALS

A report of the Director of Planning and Community Care [Board Paper No. 03/55] was submitted setting out the progress in developing proposals to establish a Service Redesign Committee.

The Scottish Health White Paper had given strong encouragement that:-

(i) frontline staff should be leaders of the change process; and

(ii) service change should be driven from the patient's perspective and grounded in everyday patient experience.

The Scottish Executive Health Department had created and distributed a Change and Innovation Fund to NHS Boards where a satisfactory Change and Innovation Plan was in place. The Service Redesign Committee would be a focal point for this work and a stated objective was to ensure that there was a strong clinical input into the development and delivery of change and innovation plans.

Two short workshops were arranged with a wide range of interests, including clinical staff managers and the Local Health Council to debate the issues around remit, membership and the connections and linkages which the Committee could most benefit from. It was recognised that the Committee needed to add value to the work of the NHS Trusts and their staff in driving service change and innovation across the massive range of services currently delivered.

A number of headline themes emerged from the two workshops, namely:-

- Resources
- Staff capacity
- Membership
- Developing the plan
- Programme of activity

and each was covered in detail in the NHS Board paper.

ACTION BY

It was intimated that Dr John Nugent would be willing to Chair the Service Redesign Committee. He stated he was keen that the Committee was formed from a balance of membership between innovators and enthusiasts and other clinical and managerial staff. He wanted to ensure that the Committee added value: he would be keen to establish the Committee by the end of the year.

Mr Goudie expressed disappointment that the Area Partnership Forum and the Trade Unions had not been involved in the debate so far; this would have been a good opportunity to exploit partnership working in this area. He was encouraged at the Partnership Support Unit being established in the North Glasgow Trust and this was an encouraging mechanism to include as many frontline staff as possible in key decisions and their involvement would lead to greater ownership and support of proposals.

The Area Partnership Forum had taken stock of all Committees and Groups across the NHS Board and Trusts to see how best staff partnership could be played in to these Committees/Groups. It was clear that there would be a capacity issue in trying to be involved in all Committees/Groups. It was recognised that there currently was staff involvement in many Committees/Groups as well as staff representatives involved in others and it was important to draw the distinction between the two.

Mrs Kuenssberg explained the process of offering bursaries or grants to individuals or teams at Yorkhill for carrying out redesign or training. This work could be shared by Helen Ostrycharz, Director of Human Resources, Yorkhill NHS Trust, if necessary.

There was already much under way in the field of redesign and innovation across a whole range of services and in forming a Committee to add value, it had to be ensured that it was complementary to what was currently under way and had appropriate linkages with relevant Committees and Groups.

Mrs Bryson and Mr Hamilton saw benefit in staff, patient and public involvement with the Committee and would work with Dr Nugent to see how this could be achieved.

Cllr. Collins suggested that a future Board Seminar should review the range of current Committees/Planning Groups, their roles and remits and how they related to each other. This would also help to identify clear linkages, any support required toward service change and encourage innovation as it interfaces with patients.

DECIDED:

1. That a seminar be held in November/December 2003 to consider the remit and structure of existing Committees and Planning Groups and how it can add value to innovation and redesign effort. **Director of Planning and Community Care**

2. That a Service Redesign Committee reflecting the discussion be established. **Director of Planning and Community Care**

115. HEALTH AND WELL-BEING SURVEY OF THE GREATER GLASGOW POPULATION

A report of the Director of Health Promotion [Board Paper No. 03/56] was submitted asking that the Board consider:-

(i) The impact of health inequalities and the effects of poverty and deprivation on health, with people in Social Inclusion Partnership (SIP) areas recording less favourable responses in all aspects of health.

(ii) That there was evidence of improvements in health since the baseline survey in 1999.

(iii) The encouraging indications that the policy of working in partnership and targeting resources and efforts to areas was resulting in positive changes in both lifestyle behaviours and life circumstances among people in SIP areas, and that in some aspects of health the inequality gap was closing.

The report summarised the main findings of the Health and Well-being Survey of the Greater Glasgow population carried out in September 2002. This was an important means of gathering information on the health status of the people in Greater Glasgow which complemented the mortality and morbidity statistics which were regularly collected. The survey collected information on aspects of people's lifestyles, their environment and personal and social circumstances that affect their health. The results were relevant to the NHS and the Local Authorities and their community planning partners in informing planning and activity aimed at improving the health and well-being and quality of life of people throughout the Greater Glasgow area.

A representative sample of 1,802 adults was interviewed about their perceptions, attitude and behaviour in relation to their physical, mental and social health. A response rate of 67% was achieved. A similar survey was carried out in 1999 acting as a baseline against which the results of the 2002 survey could be compared giving some indication of changes that had taken place in the last three years.

Thus far, the results had been analysed for the whole sample at a Greater Glasgow area-wide level only with an indication, where statistically significant, of differences between people living in SIP areas and non-SIP areas.

Key Results

(i) Perception of health and illness

Substantial differences in perceived health status were identified between SIP and non-SIP areas with those living in SIP areas consistently having a more negative view of their health than those living in non-SIP areas.

(ii) Use of Health Services

80% of respondents had visited a GP in the past 12 months and 50% had visited the dentist in the past 12 months. Residents in SIPs are less likely to be registered with a dentist (65% registered in SIPs, 75% in non-SIP areas).

The majority of health service users reported that they felt they had been given adequate information about their condition or treatment (80%); had been encouraged to participate in decisions affecting their health or treatment (70%); had a say in how the services are delivered (65%); and felt that their views and circumstances had been understood and valued (74%). 10% of people felt that they had not received adequate information and 18% of people had not been encouraged to participate in decisions affecting their treatment; 24% had not had a say in how services were delivered; and 14% did not feel that their views and circumstances were understood and valued

(iii) Health-related Behaviours

The results suggested that there had been a reduction of 4% overall in smoking. Whilst this may have been a proportional change and may not have been statistically significant at a confidence level of 99.9%, nevertheless, even a very small change in smoking rates would have had a significant effect on the health in Greater Glasgow and it was an encouraging finding.

There had been an increase in physical activity levels when compared to 1999 as well as an increase in the consumption of fruit and vegetables, a reduction in numbers of people eating high fat snacks, and a reduction in alcohol consumption. A cause for concern, however, was the high proportion of young women (16-24 years of age) who exceeded the recommended weekly limit of 14 units of alcohol.

(iv) Social Health

People in the SIP areas felt less connected and felt less of a sense of belonging and less valued as a member of their community. They also felt less safe in their neighbourhood and had a more negative view regarding problems and equality of services in their area.

Young people hanging around was the most frequently cited example of a common problem within an area (62%) and drug activity, excessive drinking, vandalism/graffiti were mentioned by around half as being very common/ fairly common problems.

(v) Changes since 1999

The majority of change since 1999 had been positive in health improvement terms – the most positive change had taken place among residents in SIP areas, suggesting that measures to promote social inclusion and tackle health inequalities had been effective.

There were some areas where things appeared to have become worse:-

1. The number of people registered with a dentist had reduced by 7%

2. The number of people eating 5 slices of bread per day had reduced by 5%

3. The number of people belonging to a club had reduced by 10%

4. The number of people expressing a positive view of their local area had reduced by 6%.

In all of these areas the changes had taken place mainly in non-SIP areas.

There had been a number of positive changes in lifestyle, namely:-

1. The number of people eating five portions of fruit and vegetables a day had increased by 10%.

2. The number of people eating more than two high fat snacks had decreased by 22%.

3. Overall, the number of people exceeding the recommended alcohol limit had decreased by 5%.

4. There had been an increase of 12% in the number of people taking at least 30 minutes moderate activity five times per week.

5. There had been an increase of 9% in the number of people living in SIP areas who felt they had control over decisions that affected their lives.

(vi) Positive Change in Life Circumstances

1. 19% more people in SIP areas felt their area was a good place in which to raise their children.

2. There was an increase overall of 9% (16% in SIPs) in people saying they felt safe walking in their area, even after dark.

3. There had been a reduction overall of 14% (21% in SIPs) in the numbers of people without educational qualifications.

4. There had been a reduction of 8% overall in the numbers of people living in a household where no-one is employed.

The results of the survey, whilst requiring to be treated with due caution, highlighted encouraging signs that positive change had been achieved in the health of the whole population and, more significantly, in relation to the policy context of those living in SIP areas. The results of the survey suggested that the policies and programmes that had been implemented had laid the groundwork for further efforts to be successful.

Dr Burns welcomed the news of the improvements within the SIP and non-SIP areas and the fact that in some aspects of health the inequality gap was closing. He remained concerned, however, that in comparison with the health of the rest of Scotland we remained a long way behind and the morbidity statistics were not giving any indication of the narrowing of the gap and that remained a major challenge for the NHS Board. Dr Burns spoke about the Scottish Life Survey which was carried out every five years and the overall picture it can provide for all of Scotland and different parts of Scotland and it would be possible to extend that survey, at a cost, to a greater number of people and with a range of additional questions. The health promotion interventions were making a significant impact; however, almost a third of people living within SIP areas reported having a long term condition or illness that interfered with their day-to-day activities. Important issues of loss of control of their lives and low self-esteem affect a person's health and a major challenge facing all the bodies involved in social policy was to see how this could be challenged and improved.

Mr Robertson was encouraged by the recorded change and reminded Members that there were deprived areas within NHS Greater Glasgow that were not confined to the SIP areas and, therefore, some of the results in the non-SIP areas were also equally encouraging. It was an important piece of work that would assist the NHS Board in working with our Local Authority partners to continue to improve matters that affected health.

Cllr. White asked if there was any further analysis and whether the survey could be extended into other areas. For this survey additional information would be available for Glasgow City, East Dunbartonshire and South Lanarkshire. There was the potential to extend this to other areas in future surveys. The survey would also be reported to the Joint Community Care Committees and Community Planning Committees with the Local Authorities.

ACTION BY

Mrs Nijjar asked about the population of the ethnic communities who had been included in the survey. Whilst they were proportional to the ethnic population within NHS Greater Glasgow's area, they were not significant enough in size to draw any particular conclusions as the sample size had been too small. Particular studies would look at this in more depth in the future.

Mrs Bryson said she had read in the local media that the North Glasgow Trust had amended its No Smoking Policy to include smoking areas within hospitals. Mr Davison replied that the North Trust was still committed to reducing smoking; however, they had taken steps to deal with a practical problem of hospital entrances being crowded with people smoking and giving a bad impression to visitors and others on entering hospitals. A discrete area adjacent to the main areas had been created to allow people to smoke and, in doing so, had improved the appearance of the front entrance of hospitals, dealt with some health and safety issues which had been raised and also complaints that had been received by management about people smoking at the entrances to hospitals.

Mrs Borland indicated that the NHS Board was still working towards the Tobacco Strategy which indicated working towards a smoke-free environment on an incremental basis and that we had to be careful, as Sir John reminded Members, not to send out mixed messages on this very important issue. Some hospitals and Trusts had very clear and explicit policies that smoking was not acceptable within hospital premises and this was reinforced by the message that smoking damaged health and the NHS should not be seen to be supporting its staff or visitors smoking within its premises.

Mrs Borland indicated that there was no shortage of challenges highlighted in this Health and Well-being Survey and in reducing smoking and that health promotion interventions would continue to strive towards making impacts into the various health targets and objectives. The results shown in this second Health and Well-being Survey had been an encouragement not only to her and her staff, but to the wide range of partners involved in work to improve health.

DECIDED:

1. That the Health and Well-being Survey of the Greater Glasgow population carried out in September – December 2002 be noted.

2. That the impact of health inequalities in the effect of poverty and deprivation on health with people in SIP areas recording less favourable responses in almost all aspects of health be noted.

3. That the evidence of improvements in health since the baseline survey in 1999 be noted.

4. That the encouraging indications that the policy of working in partnership and targeting resources and efforts to SIP areas was resulting in positive changes in both lifestyle behaviours and life circumstances among people in SIP areas and that in some aspects of health inequality gap was closing be noted. **Director of Health Promotion**

116. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/57] asked Members to note the provisional waiting list position as at 31 August 2003.

The data was presented in two formats:

ACTION BY

- Table 1 showed all NHS Board residents without availability status codes (ASCs).

- Table 2 showed all NHS Board residents with availability status codes (ASCs).

Currently, 1,059 patients waited over nine months at the end of August with no availability status (ASC) codes and it was planned to reduce this figure to zero by 31 December 2003. To achieve this:-

(i) It was planned to deliver an additional 3,200 in-patient and day case admissions to ensure that there were no waits in excess of nine months by December 2003 and sustained to March 2004.

(ii) An in-year performance review and risk assessment of specific specialties that offer the greatest challenge, e.g. Orthopaedic Surgery, be carried out.

(iii) The change in waiting time patterns on a weekly basis be monitored so that corrective action could be taken where necessary to improve performance.

Dr Nugent asked if the capacity was available to carry out the additional 3,000 in-patient and day case procedures. It was explained that between in-house initiatives, utilising the Golden Jubilee Hospital and the private sector should ensure that this level of patients is treated by the end of the year, thereafter the challenge would be to sustain the nine-month waiting time.

NOTED

117. QUARTERLY COMPLAINTS MONITORING REPORT – 1 APRIL TO 30 JUNE 2003

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No. 03/58] was submitted setting out the Quarterly Report on Complaints in NHS Greater Glasgow for the period 1 April to 30 June 2003.

It was reported that the consultation period on the Reform of the NHS Complaints Procedure had now been completed and the Scottish Executive Health Department were considering the responses to consultation. Any new procedure was likely to be implemented from 1 April 2004.

NOTED

118. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 03/59] was submitted seeking approval of three medical practitioner employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Brian Gillatt
Dr Rosemary McCaffery
Dr Myra David

119. MINUTES OF THE NHS GREATER GLASGOW ACUTE SERVICES COMMUNICATIONS MONITORING SUBGROUP: INVOLVING PEOPLE GROUP – 3 JUNE 2003

The Minutes of the meeting of the NHS Greater Glasgow Acute Services Communications Monitoring Subgroup: Involving People Group held on 3 June 2003 were noted.

120. MINUTES OF THE AREA CLINICAL FORUM MEETING – 18 AUGUST 2003

The Minutes of the meeting of the Area Clinical Forum held on 18 August 2003 were noted.

121. PERFORMANCE REVIEW GROUP MEETING – 29 AUGUST 2003

The Minutes of the meeting of the Performance Review Group meeting held on 29 August 2003 were noted.

The meeting ended at 11.10 a.m.

GGNHSB(M)03/10
Minutes: 122 - 126

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Reid Hall, Community Central Hall,
304 Maryhill Road, Glasgow, G20 7YE
on Tuesday, 7 October 2003 at 10.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Best	Mr W Goudie
Mr R Calderwood	Mr P Hamilton
Mr R Cleland	Councillor J Handibode
Councillor J Coleman	Mrs W Hull
Councillor D Collins	Mrs S Kuenssberg CBE
Ms R Crocket	Mrs R K Nijjar
Mr T Davison	Dr J Nugent
Mr T A Divers OBE	Mr I Reid
Councillor R Duncan	Mr A O Robertson OBE

Councillor A White

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

Ms E Borland	..	Director of Health Promotion
Dr L de Caestecker	..	Consultant in Public Health Medicine
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr J Whyteside	..	Public Affairs Manager

GUEST PRESENTERS

Ms C Caldwell	..	Facilitator, Maternity Services Consultation Network (MATNET)
Ms M McGinley	..	Head of Midwifery, Princess Royal Maternity Hospital
Professor M Reid	..	Chair, Maternity Services Working Group

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council

ACTION BY

122. APOLOGIES

Apologies for absence were intimated on behalf of Dr F Angell, Dr H Burns, Dr B Cowan, Mrs E Smith, Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mrs G Leslie (Chair, Area Optometric Committee), Mrs F Needleman (Chair, Area Pharmaceutical Committee), Mr H Smith (Chair, Area Allied Health Professionals Committee), and Dr B West (Chair, Area Medical Committee).

ACTION BY

123. CHAIRMAN'S INTRODUCTION

The Chairman welcomed everyone to the special meeting of the NHS Board – whose main purpose was to hear from the three groups who had been working, in a pre-consultation process, to help the NHS Board develop its proposals for formal public consultation on how modern, safe and sustainable maternity delivery services should be provided.

124. MINUTES

On the motion of Mr R Cleland, seconded by Mrs R K Nijjar, the Minutes of the meeting of the NHS Board held on Tuesday, 16 September 2003 [GGNHSB(M)03/9] were approved as an accurate record and signed by the Chairman.

125. MATTERS ARISING FROM THE MINUTES

(i) Mr Divers advised that the Chairman and himself had met with the Leader of East Dunbartonshire Council to take forward discussions on Partnership For Care. Their Joint Community Care Committee had had its first meeting and had elected Andrew Robertson as Vice Chair.

(ii) Arrangements had been made for the NHS Board's Annual General Meeting (AGM) which would be held on 23 October 2003 at 1.30 p.m. in Glasgow Royal Concert Hall.

NOTED

126 FUTURE OF MATERNITY SERVICES IN GREATER GLASGOW

A report of the Chief Executive [Board Paper No. 03/61] asked the Board to receive the reports and presentations from the Midwifery Workshop, the Maternity Services Users Network (MATNET) and the Maternity Services Working Group.

Sir John firstly explained that Maryhill Community Central Hall had been chosen as the venue for the NHS Board meeting in order to ensure that if a larger group of members of the public than typically attended NHS Board meetings wanted to attend, there would be ample accommodation. The NHS Board discussed key strategic issues in public session and this reflected one of his key priorities in his first year as NHS Board Chairman to improve communications with members of the public.

He highlighted that this meeting was a working session of the NHS Board and Members would wish to be informed by the three reports and presentations and to ask for clarification or further information in order that they would be best able to work towards the preparation of the Board's consultation document by 21 October 2003. Thereafter, that document would be made widely available for public consultation.

Sir John introduced each Member of the NHS Board.

ACTION BY

The NHS Board's Communications Team had prepared a pack of material to help all in attendance to follow the presentations and discussions. Included within the pack were a number of other articles and news cuttings which may be of background interest. The pack firstly summarised the current status of the Board's consideration of the future of maternity services in Greater Glasgow and described how it would move forward. In May 2003, the NHS Board approved a process to inform formal public consultation on how to provide modern, safe and sustainable maternity delivery services. This NHS Board paper was included in the pack. The aim of that pre-consultation process was to ensure that the critical issues affecting this decision were carefully and transparently considered in a way which enabled strong public and professional engagement.

Discussions would be through the Chair and the Board would receive and consider three reports as follows:-

- Report of the Midwifery Workshop: Mary McGinley, Head of Midwifery at the Princess Royal Maternity Hospital would speak to this.

- Report of MATNET, the Maternity Services Consultation Network: Christine Caldwell, who facilitated MATNET, would speak to this.

- Report of Maternity Services Working Group: Professor Margaret Reid, Chair of the Working Group, would speak to this.

The presentations and appraisal of these three reports were intended to allow the NHS Board to consider a formal consultation paper at its 21 October 2003 meeting – which once again would be held at Maryhill Community Central Hall. If the Board agreed its approach to consultation at that meeting, there would follow three months of consultation which would include a range of further opportunities for professional and public comment before the NHS Board made its final decision and recommendation to the Minister for Health and Community Care – where the ultimate decision rested. This formal consultation process would include:-

- Meetings at which the Board's proposals would be presented and where members of the public would be able to ask questions and express their views.

- Engagement with staff interests.

- Further engagement with other NHS Boards.

In addition, there would be a wide circulation of written material for comment by a broad range of consultees.

Each presentation was then taken in turn.

(i) <u>Report of Midwifery Workshop: Presenter - Mary McGinley, Head of Midwifery, Princess Royal Maternity Hospital</u>

Ms McGinley thanked the Board for the opportunity to present the outcome of the Midwifery Workshop which had been held on 25 August 2003 and attended by 44 midwives. The over-riding key theme from the workshop was that the reduction in the number of delivery units in Greater Glasgow should not result in a reduction in maternity care provision for women and their families. On the contrary, it should be seen as an opportunity to look more widely at the whole service.

Much of the workshop focused on the potential to significantly change the midwifery role with, in particular, greater emphasis on midwife-managed care for women experiencing a normal pregnancy – with direct access to a midwife. It was also suggested that strengthened relationships could be formed between midwives and GPs including more local geographic service structures. The opportunity to extend the public health impact of midwives was explored and there was enthusiasm for this.

Much discussion at the workshop had surrounded the impact of larger delivery units and Ms McGinley highlighted a number of important messages, including:

- The impact of larger units required to be managed to ensure that personal aspects of care were addressed and that one-to-one care in labour was achieved.
- Provision of good facilities for the mothers of sick babies was important.
- Outreach from hospital should be maximised to reduce hospital attendances and transfers.
- There should be choices of models of care within delivery units – including domino, midwifery-led and home births and this was a fundamental requirement.
- Continuing to develop high quality critical care for mothers at risk was important.
- High quality and effective neonatal transport was critical.
- Re-provision of specialist clinics needed to be properly organised.

There was a strong consensus that community services were the most important area for development and the following was highlighted:-

- There needed to be local access for the majority of care and the majority of women.
- Targeting more assertively, and with more resources, those who had not traditionally accessed services was an important developing midwifery role.
- Facilities in the community were highly constrained and needed to be addressed.
- The potential of technology, for example, tele-medicine needed to be explored.
- The Community Health Partnership provided an organisational form for much stronger relationships in primary care – a team approach to the care of women, children and families.

In terms of priorities surrounding staffing, the following had emerged from the workshop discussion:-

- The need to learn from previous closures.
- The positive impact of previous changes in developing ways of working.
- The need to ensure staff involvement in connection with their future workplace and patterns of working – recognising that there should be consistent service models but there should also be the potential for different ways of working within them.
- More practitioner involvement in decision making to raise morale and retain staff.
- Transport policy and information technology issues needed to be addressed.
- The pressures incurred when seeing increasingly different and more diverse communities (often with higher expectations and levels of need) needed to be addressed.

In summing up, Ms McGinley highlighted the most important issues to get right:-

- Service model.
- Local access to a midwife clinic.
- Ability to assess risk.
- Consultant linked to a geographical area.
- Consultant involvement in higher risk cases.
- Lessons to be learned from Millbrae and Rutherglen Maternity Community Clinics.
- Ensure high quality intrapartum care.
- One-to-one in labour.
- Ensure staff were skilled in providing critical care where required.
- Avoid separation of mothers and babies.
- Care for mothers alongside babies.

Furthermore, the critical staffing issues included the following:-

- The need to ensure adequate staffing levels and manageable midwifery caseloads.
- Education and training for new roles.
- Involvement of staff in decision making.
- Consistent service models but flexibility in ways of working.

Ms McGinley described how the workshop had given midwives the opportunity to have an intense and open discussion about a wide range of issues and implications of change to delivery units. Midwives concluded that changes could bring positive benefits and past experiences had demonstrated that it allowed new ways of working and new ideas to be introduced. Regardless of the outcome of the consultation exercise, the quality of service for women should be the same as currently provided or better.

Sir John thanked Ms McGinley for her informative and constructive presentation.

Councillor Collins asked Ms McGinley about parental involvement in the workshop. Ms McGinley advised that this strand of the pre-consultation on maternity services was focused on midwives from the three Greater Glasgow services. There had been a separate exercise seeking user, including parental views.

Mr Divers referred to the examples of good practice highlighted at Millbrae and Rutherglen Maternity Community Clinics. Ms McGinley described the services provided from there in that day care was provided in local communities with an established midwifery community base. She also highlighted that, at the moment, the Clydebank and Easterhouse Clinics were supported by midwives. In response to a question from Dr J Nugent, Ms McGinley confirmed that Rutherglen Maternity Hospital had dealt with around 3,000 births per annum. Following its closure, the Millbrae and Rutherglen Maternity Community Care Centres formed with enhanced midwifery involvement.

Mr Goudie recognised that local community services were successful in reducing hospital admissions both antenatal and post-natal. Access was, however, paramount and he encouraged the Board to think about how many services could be provided from local health centres rather than hospitals.

In response to a question from Mr Best, Ms McGinley confirmed that midwives recognised the issue of importance in avoiding the separation of mothers from babies. As such, mothers should have access to comfortable accommodation – if need be to stay overnight.

Dr de Caestecker reiterated the need for enhanced practitioner involvement in the decision making process and midwives should be closely involved in such partnership working.

In response to a question from Sir John, Ms McGinley advised that NHS Greater Glasgow had led the way in terms of having a social model of care, particularly in terms of midwifery services. In looking to English hospitals (especially in London) for ways of working, Ms McGinley advised that midwife-managed care was balanced to medical-managed care and this could be further explored in Greater Glasgow.

(ii) Report of MATNET, the Maternity Services Consultation Network: Presenter – Christine Caldwell, Facilitator

The MATNET report was based on consultation with local community groups, organisations and a special MATNET meeting set up to look specifically at reduction of three maternity units to two in NHS Greater Glasgow.

MATNET had recognised the difficult decision to be made about the future of Greater Glasgow's maternity hospitals but had agreed that one site should be closed. In concluding this, however, MATNET had had no view on which site this should be.

MATNET agreed that hospital closure could offer an opportunity to identify and implement changes in service that would benefit women and their families across the city. In taking this forward, one important issue was the need to increase maternity services within local communities giving women access to a wide range of local maternity services. In recognition of this, MATNET had considered the model of community services adopted in Rutherglen as being a highly recommended model for the city. Furthermore, antenatal classes would be greatly improved if they were provided in local community venues and Ms Caldwell described the antenatal classes currently run in Eastbank Health Promotion Centre which were very popular with women.

MATNET urged the Board to consider how it could support women to attend hospital services, particularly in relation to public transport, car parking, rest facilities and child care. When planning the hospital closure, consideration should be given to the travelling consequences to the remaining two hospital sites.

Training must be given to midwives in order to support them in taking on increased public health roles, however, other issues raised by MATNET were regarding consistency of carer with much emphasis placed on developing a relationship with a midwife. It had appeared that many women were unaware of their choice regarding where they could deliver their baby and MATNET encouraged better available information to ensure that they could participate fully in such decision making.

There was a need for better post-natal services for women and the flexibility of such support should be addressed. Ms Caldwell cited the Starting Well Project as an excellent model of needs-led support provision.

Maternity hospital facilities should be well decorated and well ventilated with windows. A model described fitting these criteria was at the Tower Suite, Queen Mother's Hospital. Facilities should also be able to accommodate partners should they need to stay at the hospital.

MATNET welcomed the opportunity to present its views at the NHS Board meeting and hoped that through its membership of the Maternity Services Liaison Committee, it would be able to continue to contribute to the plans for Greater Glasgow's maternity services.

In response to a question from Sir John, Ms Caldwell acknowledged that MATNET was a new organisation and had had its first meeting in August. Much work had been done in Greater Glasgow, including visiting local communities and groups with an interest in maternity services. She reiterated Ms McGinley's point that Greater Glasgow was a leading light in maternity services especially in its community-based services.

Dr J Nugent saw many overlapping themes between the Midwives' Workshop and the MATNET report, particularly in relation to progressing community-led services.

With regard to the access and transport issues raised, Sir John confirmed that the NHS Board was currently engaged with Strathclyde Transport to see how best transport provision could be addressed to hospital sites throughout NHS Greater Glasgow.

(iii) Report of Maternity Services Working Group: Presenter – Professor Margaret Reid, Chair

Professor Reid introduced Ms Crocket, Director of Nursing, Greater Glasgow NHS Board, who described the pre-consultation process.

Ms Crocket referred to the decision made in 1999, as part of the broader process of modernising maternity services, to reduce the number of maternity hospitals in Greater Glasgow from three to two. At that time, however, no decision was made about which hospital should close. Currently, NHS Greater Glasgow has three maternity hospitals:-

- Princess Royal Maternity Hospital opened 2001 (Level III – indicating over 3,000 babies per year).
- Queen Mother's Hospital, co-located with the Royal Hospital for Sick Children (Level III – indicating over 3,000 per year).
- Southern General Hospital (Level IIa – indicating less than 3,000 babies per year).

She described the background factors affecting maternity services since 1999, including:-

- The continuing decline in the birth rate in Scotland resulting in existing hospitals working to less than capacity.
- The imminent EU directive on Consultant Working Hours.
- Junior Doctors working hours and training meant increasing difficulty in providing rotas and on-call emergency cover in the three sites.

Accordingly, there were two options facing the NHS Board:-

1. The closure of the Southern General Hospital Delivery Unit and expansion of facilities at the Queen Mother's Hospital to deal with additional deliveries.
2. The closure of the Queen Mother's Hospital and expansion of facilities at the Southern General Hospital Delivery Unit to deal with additional deliveries.

Ms Crocket outlined the membership and remit of the working group and the pre-consultation process. The working group had held 11 evidence sessions and had heard verbal evidence from over 80 individuals. Furthermore, over 55 written responses had been received.

The working group had been supported by nine expert advisers who had been nominated by their professional bodies. These advisers had offered an objective perspective and had reviewed the working group's key issues – they had also visited all three hospital sites.

Based on all the oral and written evidence, the working group report had led to eight recommendations.

Professor Reid went on to describe the findings from the pre-consultation exercise touching on clinical issues (including maternal care, neonatal care, research and training and other services), qualitative issues, issues concerning location, estates and transport, the overall long term solution and the working group's eight suggested recommendations.

She described the procedures currently in place in Greater Glasgow's three maternity hospitals in responding to emergencies and the key factors associated with this, particularly that critically ill mothers did not transport well, therefore, such situations were time critical.

Although maternal mortality from childbirth was now very low, nevertheless, services were organised to ensure minimum risk to the mother. National and professional documents supported the decision of locating a maternity hospital on-site with a hospital with adult ITU services.

The trend of maternity hospitals in Scotland had been towards re-location to an adult hospital with on-site adult ITU facilities with 19 out of 20 hospitals now moved to, or moving to, a site co-located with adult services. The Queen Mother's Hospital would remain as the only maternity hospital without ITU on-site. Locating maternity services (for low and high risk mothers) with on-site ITU facilities allowed a rapid transfer of the woman if there were complications during labour or delivery.

As well as stressing the importance of transfers, the importance of providing access of expertise from an on-site adult ITU to the mother in an emergency situation was acknowledged.

Maternal emergencies were seen as less predictable than neonatal emergencies. This would increasingly be the case if Greater Glasgow's maternity hospitals adopted a 20-week routine anomaly scan which would provide greater likelihood of predicting the need for neonatal surgery.

Very small numbers of critically ill women would be transferred from any hospital in one year. Experience of junior medical staff on managing life-threatening emergency situations in mothers was, therefore, likely to be very limited. Staff on an adult site had more routine exposure to adult emergencies and hence more experience.

National guidance for women who might be categorised as "high risk" (for example, from areas of deprivation, older mothers, multiple pregnancies and/ or who had existing medical conditions) was that they should give birth in a hospital with on-site ITU facilities. Statistics relating to Greater Glasgow women suggested that a significant proportion would fall into a high risk category.

It was generally agreed that although staffing of the neonatal intensive care units in Glasgow was part of a national shortage, such units were thought of as appropriate in their standard of care. Neonatal transport within Glasgow and the West of Scotland was now organised to offer an appropriate standard to provide safe transport to neonates who required transporting across the city. Neonates could be safely transported to and from the Royal Hospital for Sick Children before and after surgery from other hospitals; it was stressed that such transport takes place elsewhere in the UK on a daily basis.

It was noted that the units worked to different protocols and practices and the group's experts stressed the importance of a development of midwife-led care where appropriate.

It was clear that research in this broad area was strong and that any changes to the service should ensure that research strengths were maintained.

Capital costs associated with the various options at both the Queen Mother's Hospital and Southern General Hospital had been explored and offered substantially different costs associated with refurbishment. The report concluded that, in the medium term, the Queen Mother's Hospital might not be able to provide maternity services while substantial refurbishments were being made to the building.

Transport issues were seen to affect both patients and staff and the report urged good transport provision in any future services.

Mrs Kuenssberg had been encouraged by the Midwives Workshop and MATNET reports, particularly in the overlapping areas of enhanced community services. She noted that neither group had expressed a preferred option of the future siting of Greater Glasgow's maternity hospitals. She expressed her view that more would be lost than gained by closing the Queen Mother's Hospital. The report did not explain sufficiently what would be the practical consequences of breaking the links between maternity (including foetal), neonatal and paediatric services. She was concerned at the effects on academic research and training and asked how the consultation document would acknowledge negative consequences and explain how their effects would be overcome. Mr Divers described the consultation exercise as being framed around a number of questions and options which would draw out the pros and cons of each recommendation.

In response to a question from Mrs Kuenssberg in connection with the regional and national role of the Queen Mother's Hospital/Royal Hospital for Sick Children, Ms Crocket referred to the very difficult decision to be made and the scenario planning exercises undertaken by the working group and the experts. Professor Reid stated that the transfer would not inhibit the excellent work currently being carried out.

Professor Reid acknowledged the concerns about foetal medicine but stated that their evidence pointed to the fact that there would be no detrimental clinical effect of transferring it from the Queen Mother's Hospital to the Princess Royal Maternity Hospital.

ACTION BY

In relation to the financial issues and the financial implications of moving to the preferred option, Mrs Kuenssberg pointed out that this had been included in the remit of the working group but had not formed any part of the report. Mr Divers indicated that it was not appropriate to profile financial issues at this stage of the process, but acknowledged that the NHS Board's final decision must take account of the associated financial implications. What was paramount was that the best clinical model was established.

Mr Robertson sought clarification around the eight recommendations and how inter-dependent they were on each other. Mr Divers advised that this would be a matter for the Board to discuss in determining the format of the consultation documentation.

Mr Best stated that it was difficult in the time available to give detailed comments on the report and its recommendations, however, he had a duty to support the affected staff and would be briefing them that afternoon. He was concerned that the working group had gone beyond their remit. Mr Goudie endorsed this in relation to Recommendation 8 about the long-term location of the Royal Hospital for Sick Children. Mr Divers commented that the Working Group had felt that it must make this view known to the NHS Board as it had been put forward by many of the experts whom the Group had met. He drew attention also to the bullet point under recommendation 8 in the Working Group report which stated that any decision relating to the Royal Hospital for Sick Children would require appropriate consultation and be commensurate with the Board's overall strategic and financial plan.

Mr Best referred to the child/maternal ethos, particularly in relation to mothers and children where infants required neonatal surgery. Professor Reid referred to this small group of babies and stated how impressed the working group was with the current facilities provided by the Ronald Macdonald House where mothers could stay throughout their child's care in hospital.

In response to a question from Mr Robertson, Professor Reid confirmed that the figure of £7.1 million at the Southern General Hospital included creating an additional facility for the transferred births from the Queen Mother's. With regard to the breakdown of the figures, Catriona Renfrew agreed to make available to Members the report commissioned on this issue.

Director of Planning and Community Care

Dr de Caestecker encouraged the Board not to lose sight of the main aim which was to improve child health. In line with this, Mr Divers confirmed that the consultation itself would pick up the key issues arising from the presentations and bring together in a common format.

Sir John thanked all three presenters for the work undertaken by the groups and indicated that the NHS Board would now consider the key issues as it developed its proposals for consultation on the future of maternity services for Greater Glasgow so that they can be submitted to the NHS Board on 21 October 2003 for consideration.

The meeting ended at 12.15 p.m.

GGNHSB(M)03/11
Minutes: 127 - 137

GREATER GLASGOW NHS BOARD

**Minutes of a Meeting of the
Greater Glasgow NHS Board
held in the Reid Hall, Community Central Hall,
304 Maryhill Road, Glasgow, G20 7YE
on Tuesday, 21 October 2003 at 9.30 am**

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Best
Dr H Burns
Mr R Calderwood
Mr R Cleland (to Minute 131)
Councillor J Coleman
Councillor D Collins
Dr B Cowan (to Minute No 130)
Mr T Davison
Mr T A Divers OBE (to Minute 130)
Councillor R Duncan (to Minute 130)
Mr W Goudie
Mr P Hamilton
Councillor J Handibode
Ms W Hull
Mrs S Kuenssberg CBE
Dr J Nugent
Mr I Reid
Mr A O Robertson OBE
Mrs E Smith
Councillor A White (to Minute 131)

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

Ms E Borland	..	Director of Health Promotion
Professor M Farthing	..	Principal, St George's Hospital Medical School
Ms S Gordon	..	Secretariat Manager (to Minute No 130)
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care (to Minute 130)
Professor S Smith	..	Head of Department of Obstetrics & Gynaecology, University of Cambridge
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mr J Cassidy	..	Chair, Area Nursing and Midwifery Committee (to Minute 130)
Mr C Fergusson	..	Chair, Area Pharmaceutical Committee
Ms G Leslie	..	Chair, Area Optometric Committee (to Minute No 130)
Mr J McMeekin	..	Vice Convener, Greater Glasgow Health Council
Mr H Smith	..	Chair, Area Allied Health Professionals Committee
Dr B West	..	Chair, Area Medical Committee (to Minute No 130)

ACTION BY

127. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Ms R Crocket, Mrs R K Nijjar and Mrs P Bryson (Convener, Greater Glasgow Health Council).

Sir John welcomed Professor Stephen Smith who had been appointed as Executive Dean of the Medical School, University of Glasgow (successor to Professor Michael Farthing). Professor Smith would take up post in January 2004.

Sir John also welcomed Professor Farthing who had been a member of the Maternity Services Working Group (chaired by Professor Reid) set up to undertake part of the pre-consultation process.

Sir John then welcomed everyone to the NHS Board meeting and particularly those in attendance to hear the discussion around the next steps of modernising maternity services in Greater Glasgow.

128. MINUTES

On the motion of Mr R Calderwood, seconded by Dr J Nugent, the Minutes of the meeting of the NHS Board held on Tuesday, 7 October 2003 [GGNHSB(M)03/10] were approved as an accurate record and signed by the Chairman.

129. MODERNISING MATERNITY SERVICES – THE NEXT STEPS

A report of the Chief Executive and Director of Planning and Community Care [Board Paper No 03/62] asked the NHS Board to endorse the proposals, derived from the recently concluded pre-consultation process, as the basis for formal public consultation on modernising maternity services. The NHS Board was also asked to endorse the proposed approach to consultation including the development of accessible public material. Furthermore, the NHS Board was asked to note the strong clinical advice about the co-location of adult, maternity and children's hospital services emerging from the pre-consultation process and consider its response.

Sir John began by clarifying that all documentation considered by the NHS Board so far had been part of a pre-consultation process – the purpose of which was to gather views of all key stakeholders on how maternity services in Greater Glasgow should be shaped and to ensure that this influenced the NHS Board's thinking. Views from local clinicians across NHS Greater Glasgow were in clear conflict and, therefore, the approach taken by Professor Reid, independent chair of the pre-consultative Working Group, was to seek external views from experts across the full range of clinical interests. The Working Group report had been written independently and had not been constrained or influenced by the NHS Board.

Sir John outlined the expectations from the NHS Board meeting in that it should consider the evidence and recommendations put before it to agree the terms of consultation prior to a final decision being made on the future of maternity services. The consultation paper would include a clear set of questions on each of the key points being consulted upon. He re-enforced the fact that the NHS Board was not closed to alternative suggestions but there should be no doubt that the status quo was not an option.

Sir John emphasised that whatever the outcome of the consultation, maternity services would be planned around the continuing presence of the Royal Hospital for Sick Children at the Yorkhill site for at least the next 15 years. The NHS Board had considerable investment plans involving several initiatives over the coming years and the Royal Hospital for Sick Children would continue to serve the needs of children for the next 15 years at least. He re-iterated that Greater Glasgow must modernise and change its maternity services if it was to meet the needs of mothers and babies in the future. To this end, he referred to a petition he had received prior to the meeting from Sandra White, MSP signed by people concerned to save Yorkhill. The petition signed by 1,620 people stated:

ACTION BY

"We the undersigned note with concern the threat to the Queen Mother's Maternity Hospital and Yorkhill Hospital due to the Maternity Services Review currently ongoing by NHS Greater Glasgow, further notes the special link between the Queen Mother's and Yorkhill Hospital and calls for the retention of both hospitals".

He assured all in attendance that the future of the Royal Hospital for Sick Children formed no part of the consultation process of modernising maternity services.

Sir John detailed the challenge facing the NHS Board; the undisputable fact of a significantly falling birth rate (a paper had been tabled highlighting the birth projections and historical trends for residents of NHS Greater Glasgow) and changes in clinical organisation required the NHS Board to reduce the number of maternity units from three to two. On this there was strong clinical agreement, however, there was no clinical consensus on which site should be retained and developed in addition to the new Princess Royal Maternity Hospital (PRMH). It was important to deliver clinical safety to mothers and babies and the discussion and decision could no longer be delayed. Sir John invited Mr Divers to present the proposals contained in the paper "Modernising Maternity Services – the Next Steps".

Mr Divers reminded the NHS Board that its Maternity Services Strategy, approved in 1999 following an intensive process of public and professional debate, had included the decision to reduce the number of delivery units in Glasgow from three to two. He outlined the key reasons for this conclusion being reached. Deciding on which hospital should be developed as Greater Glasgow's second delivery unit (alongside the PRMH) was always going to be a difficult decision. It was important to see this decision in the context that, while it was a key decision about a core part of the NHS Board's maternity services, for the vast majority of women, almost all of their care during the normal process of pregnancy and birth was provided by midwifery, medical and primary care staff working in community settings. The NHS Board's proposals, therefore, reflected that reality and included important questions about the development of the community and midwifery services particularly as the NHS Board's objective was to provide high quality and safe hospital care with a focus on resourcing community services.

In May 2003, recognising the difficulty of charting the way forward, and with full commitment to public involvement, the NHS Board established a major pre-consultation exercise. This had ensured that before developing proposals for formal consultation, all of the critical issues had been considered in a way which enabled strong public and professional engagement. This pre-consultation process had had three strands:

- A working group, independently chaired, and including three Non Executive Board Members, with a remit to:

  - Comprehensively review and provide advice on how to provide modern, safe and sustainable maternity delivery services for our population as the final stage of implementation of the Maternity Services Strategy.

  - Carry out its work in a fully engaging, transparent and accessible way.

  The Working Group report – produced from a detailed review of policy guidance, external clinical guidance, visits to the hospital sites, written evidence and a number of public sessions which enabled clinical and other staff to offer their views was attached with the Board papers.

- A workshop for midwifery staff from all three services offering the opportunity for practitioners to give their perspective on the future organisation of services – their report was attached with the Board papers.

ACTION BY

- The development of a report of the Maternity Service User Network (MATNET) which was established by the Maternity Services Liaison Committee in May 2003 to develop and support user involvement in the planning, management and delivery of maternity services – their report was attached with the Board papers.

It was important that the NHS Board considered the recommendations of all three reports in moving to formal consultation and the proposals for consultation were directly drawn from the issues raised throughout the pre-consultation process.

Mr Goudie sought clarification around a very recent request from the Minister of Health and Community Care about the future of maternity services in Argyll and Clyde NHS Board and the need to discuss the outcome with NHS Greater Glasgow. Ms Renfrew confirmed that the Minister had asked NHS Greater Glasgow to liaise with NHS Argyll and Clyde to look at the pattern of maternity services particularly for those residents of Dumbarton and patients who currently attended the Vale of Leven Hospital. The NHS Board had been asked to report back to the Minister by April 2004. Ms Renfrew indicated that the Minister's question would be addressed and referred to the link between this piece of work and the consultation process but highlighted that it was not significant in terms of the consultation process itself or the impact on the number of maternity units needed in NHS Greater Glasgow. It would be important to provide the right community support and recognise the patients' choice.

Mr Divers referred to the proposed consultation process and how the planning of future services in Glasgow must take account of developments in other NHS Boards. To this end, over the last five years, the NHS Board had worked closely with Lanarkshire and Argyll and Clyde NHS Boards as they had developed and implemented proposals to change maternity services to ensure a co-ordinated approach.

A small number of women, from outside the West of Scotland, currently accessed services at the Queen Mother's Hospital, including Fetal Medicine, and the NHS Board had, therefore, kept all NHS Boards and the National Services Division of the Scottish Executive Health Department in touch with the pre-consultation process.

Mr Divers acknowledged the substantial level of stakeholders who had already been engaged in the process but was mindful that the NHS Board needed to ensure that the phase of formal consultation enabled all interested parties to express their views before final decisions were reached.

Accordingly, it was proposed that the consultation be firmly rooted in the outcome of the three strands of the pre-consultation process and as such, specific consultation questions had been developed into key themes. The NHS Board would test the final proposals for decision against the points raised in the consultation. A firm evidence base must be the basis on which the NHS Board came to its final conclusion.

Mr Divers referred to the information being accessible in user friendly information leaflets to ensure the consultation was fully engaging. This would be complemented by more detailed material and online information via the NHS Board's website (www.nhsgg.org.uk). Additionally, all written material submitted to the Maternity Services Working Group would be made publicly available. The proposed timescale for the consultation was from the beginning of November 2003 until the end of January 2004, enabling a full report and recommendations to be made available at the February 2004 NHS Board meeting.

Councillor Collins commended the pre-consultation process but sought a further step to ensure that, prior to the formal consultation exercise deadline, all data and information received was appropriately analysed under each of the question headings to ensure that the NHS Board was being transparent and open to all new ideas. Mr Divers took on board this comment and encouraged consultees to respond at an early stage to ensure that all issues were appropriately analysed – there was an advantage in such a stage in the process to ensure that full justice was done to all consultees' comments.

In response to a question from Mr Robertson, Mr Divers appreciated that the consultation period included the holiday periods of Christmas and New Year and clarified that there was flexibility over the final consultation response closing date.

Mr Divers outlined the key issues for consultation drawing together the recommendations of the pre-consultation reports. These were as follows:

(i) The Location of Delivery Services

(ii) The Future Organisation of Maternity Services in Greater Glasgow

(iii) Sustaining the Quality of Services

(iv) Accessible Antenatal and Day Care

(v) The Development of Midwifery Services

(vi) The Future Arrangements for Fetal Medicine

(vii) Access and Transport

(viii) Services at the Royal Hospital for Sick Children

Each was taken in turn.

(i) <u>The Location of Delivery Services</u>

Mr Divers outlined the consultation proposal which was that:

"Delivery services should be located in the new facilities at the Princess Royal Maternity Hospital and high quality provision at the Southern General Hospital."

He referred to the Working Group recommendations and the points raised about location by the Midwifery Workshop and MATNET. As a result of this, three consultation questions had been posed on the location of the second service.

Dr Cowan referred to the difficult decision to be made but re-iterated that regardless of the choice of location, there was a need in NHS Greater Glasgow to move from three sites to two. This was being compounded by the intense difficulties establishing on-call rotas particularly with the new junior doctor hours and the European Working Time Directive which meant that rotas could not be sustained for three maternity sites in Glasgow. This was based on the fact that there required to be a minimum amount of clinical cover provided with maternity regardless of the amount of deliveries. Accordingly, it was paramount to utilise better the scarce skilled staff that were available.

ACTION BY

Mr Goudie referred to the conclusion reached by the Working Group that the development of the Southern General was the preferred site for the second delivery unit but that the Midwifery Workshop and MATNET had not come to a conclusion on which site should close. As such, he was of the view that the consultation process should pose two questions, providing a choice of facilities at the Princess Royal Maternity Hospital and the Southern General Hospital or the Princess Royal Maternity Hospital and the Queen Mother's Hospital.

Mr P Hamilton, who had been a member of the Working Group, referred to the pre-consultation process which had lasted for three months. Following all the views received, the Working Group had come to a judgement. Accordingly, he did not feel the need for the two options concerning siting of the second service to be explored further via the consultation exercise.

Councillor White considered the two options should go to consultation particularly as all the written evidence made available to the Working Group had not yet been seen by all NHS Board Members. It was important that all comments received by the Working Group were considered by the NHS Board and not just the views of the Working Group itself.

Dr Nugent considered that the first consultation question (location of delivery services) swept up any factors not already considered and this question itself afforded the opportunity for consultees to express a view on their preferred site for development of the second service.

Dr Burns referred to the fact that there was no clinical consensus across the city for the location of the second delivery unit. He referred to the view of Obstetricians who were finding their rotas very difficult to support three delivery units at the moment – this problem also impinged on General Anaesthesia where staff were stretched covering the necessary rotas. He considered Professor Reid's Working Group report to have been a comprehensive listening exercise and expressed a view that the consultation exercise should ensure that all other fourteen Scottish NHS Boards were invited to respond as the model of care at Yorkhill provided a service to the whole population of Scotland.

Professor Farthing supported the views of Dr Burns and Mr P Hamilton and encouraged the NHS Board to remain focussed with its prime concern being for the care of babies and mothers. The Working Group had already heard some compelling evidence from a range of experts and from the pre-consultation stage and consultation exercise itself. This evidence led to the clear conclusion that the Southern General Hospital was the best option and that should be the basis for consultation.

Councillor Collins referred back to the choice potential consultees would have to express views through the proposed questions.

Mr Cleland acknowledged it was important that the NHS Board conduct an open, fair and transparent consultation vehicle to provide this (in accordance with the Health Department's Interim Guidance on Consultations) which suggested clear options should be presented for public consultation.

In response to these concerns about the wording of the consultation proposals, Mr Divers referred to the Working Group remit which had been set by the NHS Board. The Working Group had carried out their scrutiny in accordance with this remit and the questions on page 16, paragraph 3.4 of the Board papers allowed consultees to offer their comments on the location of the second site.

Councillor White considered that the Working Group had expressed a view but the NHS Board must be satisfied prior to engaging in consultation that it accepted this view and had looked at all written evidence. Furthermore, it was important to look at the poverty and deprivation issues in Greater Glasgow particularly as the Minister of Health and Community Care had suggested greater collaboration between Greater Glasgow and Argyll and Clyde NHS Boards in the eventuality that there may be other options to explore.

Mr Robertson referred to the interdependence of some of the Working Group's recommendations and highlighted that the recommendation under discussion could not be looked at in isolation.

Mr Davison recognised this was always going to be a difficult decision but considered that the pre-consultation process ensured that the formal consultation process was much more informed and open. The NHS Board should consult on a clear proposal in line with the Working Group's report but ensure that other views could be expressed.

Mrs Kuenssberg referred to the urgency to move forward particularly with the impact the uncertainty had on staff. On reflection she suggested a potential compromise in that, the wording of the three questions should make clear that if consultees did not support the location of the second service at the Southern General Hospital site, then they would support it at the Queen Mother's Hospital site. Mr Divers agreed to take this point on board.

Councillor Duncan was anxious whether, as two of the three pre-consultation groups had not come to a conclusion about the siting of the second delivery unit, the NHS Board had a basis to consult on the proposed closure of the Queen Mother's Hospital. This should be the purpose of the consultation exercise itself. In response to this, Mr Divers highlighted that there was never an expectation that the other two groups would come to a conclusion regarding the siting of the second delivery unit. That was a specific part of the remit for the Working Group. The consultation exercise would be designed to test the evidence and assumptions made by the Group and to generate further evidence from consultees.

Mr Divers agreed to amend the questions of the location of the second site along the lines suggested by Mr Davison and Mrs Kuenssberg.

(ii) <u>The Future Organisation of Maternity Services in Greater Glasgow</u>

Mr Divers referred to the consultation proposal that:

"There should be greater consistency and co-ordination in the organisation of maternity services with a Glasgow-wide approach to service delivery."

All three pre-consultation reports offered important recommendations about the organisation of maternity services and the NHS Board was committed to considering the full range of those recommendations in reaching final decisions about services across Greater Glasgow. Accordingly, the consultation questions had been focussed on how best this could be achieved.

Mr Goudie agreed with the proposal but asked Mr Divers to consider again the last bullet point of paragraph 4.2 in light of the implications raised in the White Paper : Partnership for Care.

(iii) Sustaining the Quality of Services

The consultation proposal was that:

"The important quality of service issues outlined needed to be fully reflected in the NHS Board's final reorganisation of services."

Many of the points raised by the three pre-consultation Working Groups would need to be dealt with in greater detail as part of the process of implementing change.

Mr Goudie commended the proposals for sustaining the quality of services but suggested that if there were a rewording to the questions relating to the location of delivery services then the second question in this section would have to be reworded to reflect the choice to be made.

Councillor White was unclear as to how the NHS Board could avoid separating mothers from their sick babies if a mother was in the Southern General Hospital but the baby in the Royal Hospital for Sick Children. Miss Renfrew confirmed that avoiding separation for a period may not be possible on all occasions.

(iv) Accessible Antenatal and Day Care

The proposal for this was that:

"developing and improving community services would be a core part of the NHS Board's proposals for service change."

The feedback from the pre-consultation highlighted the importance of the provision and development of community services from the point of view of women and frontline staff.

The proposed consultation questions were worded to encourage comments on how best this could be achieved.

In response to a question from Mr Robertson, Ms Renfrew confirmed that, to add clarity, a detailed leaflet would be compiled outlining where women currently delivered their babies in Glasgow and teasing out issues of patterns of attendances.

(v) The Development of Midwifery Services

The proposal in relation to this section of the consultation was that:

"The NHS Board's final re-organisation of services would include specific proposals to develop midwifery services which were central to the provision of high quality maternity care. The NHS Board wanted to ensure best practice and consistent care were provided across Greater Glasgow."

Mr Divers reported that this was another area which emerged as of major significance during the pre-consultation process.

Mr Reid referred to the strengthening relationship with GPs, within local geographic service structures and highlighted how Community Health Partnerships and the GMS contracts could dovetail with this process. Dr Nugent echoed this view.

Mr Best commented that currently within Greater Glasgow there were three operational models of midwifery care. He reminded the NHS Board that MATNET had recommended the facilities at the Tower Suite in the Queen Mother's Hospital be used as a model for maternity facilities in the future.

(vi) Future Arrangements for Fetal Medicine

The consultation proposal for this was that:

"Fetal medicine services currently provided at the Queen Mother's Hospital would be transferred to the Princess Royal Maternity Hospital providing a single consolidated service for the West of Scotland and including current national services provided at the Queen Mother's Hospital."

The fetal medicine service at the Queen Mother's Hospital was an important centre providing local, regional and national services; ensuring it was sustained and developed was critical. A significant issue arising from a decision to close the Queen Mother's Hospital would be the best future arrangements for fetal medicine.

Mr Goudie asked that if the conclusion was that the Queen Mother's Hospital remained open (with the Southern General Hospital Maternity closing), then would the fetal medicine service stay intact at the Queen Mother's Hospital.

Mr Calderwood referred to NHS Board's commitment to build a centre of excellence for fetal medicine and suggested that the outcome of the consultation should be the time to retest the best siting arrangements for these services.

(vii) Access and Transport

The consultation proposal was that:

"The final modernisation proposals should clearly take account of access and transport issues, mainly by delivering as much service as possible in community settings."

In any service change, access and transport emerged as important issues. It was important to emphasise that it was not proposed that all women who presently delivered at the Queen Mother's Hospital would need to access services at the Southern General Hospital. Of the 3,200 women who presently delivered at the Queen Mother's Hospital, the NHS Board would expect around half to access services at the Princess Royal Maternity Hospital.

In response to a question from Dr West, Ms Renfrew clarified that women could choose which hospital they wished to deliver their baby in but midwives would have links with certain GP practices and hospitals.

Councillor White welcomed this section but was still concerned at the number of pregnant women from the north of the city that may have to attend the south should the Southern General Hospital site be the one chosen for development. Councillor Handibode re-iterated the crucial development of an integrated transport system.

Councillor Coleman explained that Glasgow City Council was currently undertaking a major transport study and Mrs Smith highlighted that transport was a crucial issue for all patient groups, not just confined to maternity services.

Ms Renfrew pointed out that the proposals contained within the draft consultation document suggested a wider range of services could be delivered in the community where local access would reduce transport problems.

(viii) Services at the Royal Hospital for Sick Children

The proposal was to:

"Consider what was an appropriate, separate, further process to decide what long-term decisions were required on the future of Children's Hospital services."

As Sir John had made clear at the beginning of the meeting it was proposed that the NHS Board did not need to seek comment on this recommendation at this stage but concluded that a future, separate process should be considered to advise on the pattern of hospital services for children. There was no suggestion of relocation of the Royal Hospital for Sick Children in the short or medium term (fifteen years). Throughout this process the NHS Board had been clearly, publicly committed to that position.

In light of this, Mr Goudie suggested that this proposal was not included in the consultation.

Mr Divers described how the change would be managed particularly in relation to supporting staff. Recognising that staff were highly committed and dedicated to the services they provided, the aim was to manage change as well as possible and Mr Divers highlighted a number of principles that were important in establishing detailed proposals to ensure the changes were managed as smoothly as possible.

Many staff had had the opportunity to participate in the pre-consultation exercise and it was also critical that staff expressed their views through the consultation process. If the conclusion, following the consultation exercise was that the Queen Mother's Hospital should close, staff would be redeployed into the expanded services at the Princess Royal Maternity Hospital and the Southern General Hospital. Indeed this would hold whatever the final outcome. The detailed arrangements for this, however, could not be put in place until a final decision was reached and dialogue would begin with individual members of staff.

Mr Reid commented that there would be opportunities for staff to move into roles within the community as well as the two maternity hospitals. Mrs Smith emphasised that regardless of the choices made, staff must be supported throughout the process to prevent any further uncertainty.

In terms of financial issues, Mr Divers pointed out that the review was not driven by a financial agenda – the focus had been on clinical sustainability and safety as well as the continued commitment to excellence that typified Glasgow's Maternity Services. During the consultation process, financial modelling, reflecting the proposals and questions raised in the consultation paper, would be undertaken to ensure that the NHS Board's final recommendations included appropriate analysis of financial issues.

Mrs Kuenssberg welcomed the broad scope and tone of the consultation questions which should encourage wide-ranging open debate on all issues.

ACTION BY

Referring to the Chairman's emphasis on the need for conclusions to be "evidence-based", Mrs Kuenssberg stressed that the issues involved in the debate were extremely complex. As such, the quality of the public consultation would crucially depend on accurate and comprehensive information being made available to all who wanted it about current services and the consequences of the proposed changes. Above all, NHS Board Members needed to remind themselves that the overall aim of the whole exercise was to improve services to mothers and babies.

Dr Burns agreed to encourage the other fourteen Directors of Public Health in Scotland to look at Professor Reid's Working Group report and conclude how services would be impacted within their own NHS area.

Councillor White stressed that he did not agree with the question relating to the location; Ms Renfrew emphasised that the NHS Board had already agreed the question was to be amended to reflect the comments about a choice of site. Councillor White also sought fuller information from officers on the collaboration with Argyll and Clyde NHS Board to ensure that these proposals did not cut across the NHS Board's plans.

In response to a question from Councillor Collins, Mr Divers confirmed that there would be an opportunity for all NHS Board Members to see the reworded consultation questions prior to their general distribution.

Mrs Borland re-iterated that there was a whole host of proposals being consulted on and not simply the siting issue – it was important to reflect this in the final consultation document.

It was agreed that in view of the likely timescale required to issue the proposals for consultation and the holiday period in December that there would be flexibility around the final date for responses.

Sir John summed up by referring to the difficult decision that had to be made but reminding all in attendance that no decision had been made today – the discussion had been to decide on the best form of wording for the consultation proposals. Given the views raised, the questions would be changed and reworded reflecting these views prior to its wide distribution.

DECIDED:

- That the proposals in the paper, derived from the recently concluded pre-consultation process, as the basis for formal public consultation on modernising maternity services be endorsed. **Chief Executive/ Director of Planning and Community Care**
- That the proposed approach to consultation including the development of accessible public material be endorsed. **Director of Planning and Community Care**
- That the strong clinical advice about the co-location of adult, maternity and children's hospital services emerging from the pre-consultation process be noted but that future arrangements for children's services would not be included in this consultation exercise. **Director of Planning and Community Care**

130. BEATSON ONCOLOGY CENTRE – ACTION PLAN

A report of the Chief Executive and Medical Director, Beatson Oncology Centre [Board Paper No 03/63] provided an update on the progress in implementing the recommendations of the Expert Advisory Group and asking the NHS Board to consider whether it was now timely for the Minister for Health and Community Care to be asked to return the Beatson Oncology Centre to management within the North Glasgow University Hospitals NHS Trust.

ACTION BY

Substantial progress had been made in implementing all of the key recommendations within the Expert Advisory Group's report with the exception of the specific recommendation made about returning the numbers of Consultant Clinical Oncologists to their level prior to the resignations tendered in 2001. Dr Burns reported that a recent appointment had been made and discussions were continuing with other potential candidates for both clinical and medical oncology posts. He was also encouraged that clinical staff who were receiving their training at the Beatson Oncology Centre were expressing a desire to continue to work within the Centre once their training had been completed.

Professor Alan Rodger, the newly appointed Medical Director of the Beatson Oncology Centre, had had the opportunity over the past four months to establish himself in his post and develop working arrangements with his senior colleagues within the Beatson Oncology Centre. It was his view that it was timely to return the full management responsibility of the Centre to North Glasgow University Hospitals NHS Trust. The Expert Advisory Group recommended that the Beatson Oncology Centre should operate as a discreet division within the Trust and had also made the point that this division should encompass the responsibility for Haemato-oncological services within north Glasgow. It is proposed, therefore, that an expanded division be created over the coming months as part of the arrangements for taking forward the implementation of the "Partnership For Care" White Paper. There is strong support among the affected clinicians for the integration of the Haemato-oncological services within this expanded division.

It was proposed that Professor Rodger, as Medical Director, should have a direct line of accountability to the Trust Chief Executive.

Mr Davison indicated that arrangements at the Beatson Oncology Centre had stabilised significantly and the additional capital and revenue investment had been most welcome. However, he warned that there still continued to be very significant financial pressures on the Centre's budget and, in particular, in chemotherapy costs. If the Centre was to be returned to the North Trust it needed to be seen in the context of currently being in an overspent position. He believed that this would be manageable within the current financial forecasts for 2003/04 but the high cost pressures of cancer drugs, as highlighted by Dr Burns, would continue to be a significant problem for the Centre. The escalating costs of medicines would form part of the fundamental review of the NHS Board's financial framework for the coming years.

Mrs Hull indicated that she would look in detail at the costs highlighted and would be happy to support specific pilot areas for programme budgeting.

DECIDED:

That the Minister for Health and Community Care be asked to give consideration to returning the Beatson Oncology Centre to management within the North Glasgow University Hospitals NHS Trust. **Chief Executive**

131. 2003/04 CAPITAL ALLOCATIONS UPDATE AND BEYOND

A report of the Director of Finance [Board Paper No 03/64] was submitted giving an update on the progress of the capital allocations for 2003/04 which had been agreed by the NHS Board in March 2003.

Mrs Hull advised that in reviewing proposals from NHS Trusts priority had been given to schemes that:

(i) enabled the acute services reconfiguration/implementation;

(ii) ensured adequate provision for ongoing commitment for regular investment in medical equipment, maintenance, IT, health and safety and decontamination; and

(iii) recognised NHS Trust-specific priorities

The 2003/04 Capital Plan had been agreed by the NHS Board in March 2003 and given the challenging in-year revenue position, exceptionally it had been agreed that some underwriting from capital would be necessary on a non-recurrent basis covering land sales and contribution from slippage up to a total of £19 million.

The information contained in the report confirmed that the expected £10 million slippage assumed in setting the plan had already materialised in-year. Consequently, the expected over-commitment to be offset against next year's (2004/05) capital allocation had reduced to £3.675 million.

The in-year position had changed from that originally proposed as a consequence of:-

(i) slippage on schemes;

(ii) agreement to defer schemes not yet started into next year and beyond; and

(iii) inclusion of new unavoidable requirements for capital in-year – this included joint futures/homelink joint store, social inclusion partnerships and additional cost of Aseptic unit – all totalling £2.47 million.

There was also a reduction in the £5 million revenue underwrite requirement to £2.5 million as a result of further sales receipts.

This clearly had an impact on 2004/05 and beyond and this was set out in tables in the paper which profiled the position for the four years from 2004/05. The commitments indicated were, at this stage, only indicative and there needed to be a further review to confirm requirements.

Mrs Hull also reported that the Scottish Executive Health Department had asked that capital to revenue transfer requirements for the five years to 2007/08 are confirmed. It is hoped that this information may be used to agree a permanent level of transfer across the NHS.

In summing up, Mrs Hull indicated that this report had provided an update on the in-year 2003/04 capital allocation. As the result of slippage and re-phasing the potential carry forward requirement into 2004/05 had been significantly reduced from that originally proposed.

In reply to a question from Councillor Handibode, it was confirmed that the commitment to partner agencies under the joint futures/homelink involved Local Authorities beyond just the City of Glasgow.

Mr Davison intimated that any speeding up of the rationalisation of specialties would require some level of capital investment and Mrs Hull indicated that she was keen to maintain a flexibility within the Capital Plan to be able to deal with emerging priorities.

Mr Goudie reminded the NHS Board that it had given a commitment not to reduce the in-patient acute beds at Stobhill until the medical receiving facilities at Glasgow Royal Infirmary had been improved.

ACTION BY

The Performance Review Group were undertaking with the NHS Board's Directors, a fundamental review of the financial framework for future years and there would be detailed discussion around many issues before firming up on a financial plan for the next three to five years. Mrs Hull advised that the next meeting of the Performance Review Group would be held on Wednesday, 22 October 2003 and it would consider issues relating to the ACAD Procurement Process; revenue position for 2003/04; and the Laundry Business Plan. All NHS Board Members had been invited to attend.

DECIDED:

1. That the re-profiled Capital Allocations for 2003/04 be approved. **Director of Finance**

2. That the slippage and re-phasing consequences are broadly affordable into 2004/05 and beyond, be noted.

3. That the new unavoidable requirements in-year of £2.47 million be approved. **Director of Finance**

4. That the capital to revenue transfer requirement, as advised by the Scottish Executive Health Department, be approved. **Director of Finance**

132. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/65] was submitted providing information on the progress against the key national target to have no in-patients or day case patients waiting longer than nine months from December 2003.

Mr Calderwood intimated that with 774 patients waiting over nine months at the end of September 2003 with no availability status codes that this showed a 45% decrease on the position in September 2002. Recognition was given to the significant effort made by clinical and other members of staff in achieving this decrease although it was recognised that there required to be a number of further initiatives in conjunction with the Trusts to ensure that the NHS Board delivered the planned position of no in-patient or day case patients waiting over nine months by 31 December 2003.

NOTED

133. MINUTES OF THE PERFORMANCE REVIEW GROUP MEETING – 23 SEPTEMBER 2003

The Minutes of the meeting of the Performance Review Group held on 23 September 2003 were noted.

134. MINUTES OF THE STAFF GOVERNANCE COMMITTEE MEETING – 16 SEPTEMBER 2003

The Minutes of the meeting of the Staff Governance Committee held on 16 September 2003 were noted.

135. MINUTES OF THE AUDIT COMMITTEE MEETING – 30 SEPTEMBER 2003

The Minutes of the meeting of the Audit Committee held on 30 September 2003 were noted.

ACTION BY

136. MINUTES OF THE RESEARCH ETHICS GOVERNANCE COMMITTEE MEETING – 22 SEPTEMBER 2003

The Minutes of the meeting of the Research Ethics Governance Committee meeting held on 22 September 2003 were noted.

137. GLASGOW CITY COUNCIL – JOINT COMMUNITY CARE MINUTES – 5 SEPTEMBER 2003

The Minutes of the meeting of the Social Care Services Committee – Joint Community Care meeting of 5 September 2003 were noted.

The meeting ended at 12.50 pm

GGNHSB(M)03/12
Minutes: 138 - 149

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 18 November 2003 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Dr H Burns
Mr R Calderwood
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B Cowan
Mr T Davison
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie
Mr P Hamilton
Ms W Hull
Mrs S Kuenssberg CBE
Dr J Nugent
Mr I Reid
Mr A O Robertson OBE
Mrs E Smith

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

Ms E Borland	..	Director of Health Promotion
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Professor S Smith	..	Head of Department of Obstetrics & Gynaecology, University of Cambridge
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Mr C Fergusson	..	Chair, Area Pharmaceutical Committee

ACTION BY

138. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Best, Ms R Crocket, Councillor J Handibode, Mrs R K Nijjar, Councillor A White, Mr A McLaws, Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Ms G Leslie (Chair, Area Optometric Committee), Mr H Smith (Chair, Area Allied Health Professionals Committee) and Dr B West (Chair, Area Medical Committee).

139. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

ACTION BY

(a) A meeting had been held with the new Principal and management team associated with medicine at the University of Glasgow. Sir John had been accompanied to this meeting by senior NHS Board officers. The Group had discussed several headline issues which could be jointly developed.

(b) Sir John and Ian Reid, Chief Executive, Greater Glasgow Primary Care NHS Trust, had met with all Greater Glasgow's Further Education establishments to take forward workforce development issues. Mr Reid advised that this would be further discussed at the Area Partnership Forum meeting scheduled for 1 December 2003 and it was anticipated an NHS Board seminar session would be devoted to workforce planning issues early in the New Year. Mr Reid had also met with a representative from Scottish Enterprise who had offered to assist with the NHS Board's work. Sir John reported that he was also a Member of the National Workforce Committee for NHS Scotland who were looking at various categories of workforce planning and this work was gathering pace effectively for the whole of NHS Scotland.

NOTED

140. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following issues:

(a) A joint meeting had taken place at the Health Department on 7 November 2003 with representatives from NHS Argyll and Clyde, Ayrshire and Arran, Highland, Greater Glasgow and the Scottish Ambulance Service. This had given an opportunity to link strategies and share key connections in developing health care services. A further joint Executive meeting had also been scheduled for the first week in December with NHS Argyll and Clyde to take forward the key issues of acute services, maternity services and mental health.

(b) Mr Divers had attended a meeting chaired by Councillor Collins on 11 November 2003 at East Renfrewshire Council. This had been a positive meeting discussing the development of Community Health Partnerships and key priorities of action for the next couple of months prior to formal consultation.

(c) A meeting of the West of Scotland Planning Group had been held on Monday 17 November which had given representatives from the six NHS Boards an opportunity to discuss issues of common interest. One area that had progressed was the agreement that a feasibility exercise be conducted in relation to Cardiothoracic Services and the proposal that the Golden Jubilee Hospital play a greater role in service provision for the surgical services currently delivered from the Glasgow Royal and Western Infirmary and from Hairmyres Hospital.

There was also a growing recognition of the pressures around emergency care and a collective piece of work would be taken forward across the West of Scotland in parallel with work that was ongoing in this area in NHS Greater Glasgow.

NOTED

141. MINUTES

On the motion of Mr P Hamilton, seconded by Dr J Nugent, the Minutes of the meeting of the NHS Board held on Tuesday, 21 October 2003 [GGNHSB(M)03/11] were approved as an accurate record and signed by the Chairman.

142. MATTERS ARISING

(a) Item 129 "Modernising Maternity Services – The Next Steps"

Ms Renfrew had previously circulated to all NHS Board Members an update on the consultation process and planning activity for Maternity Services. The consultation process had been launched on the NHS Board's website and the associated leaflets had been widely distributed.

Mr Goudie confirmed that the Area Partnership Forum was encouraging NHS Greater Glasgow's individual Trust Partnership Forums to hold meetings to discuss the consultation proposals and feed their comments into the Area Partnership Forum. He encouraged all staff to comment during the consultation process. The next Area Partnership Forum meeting was scheduled for 1 December 2003 when it was envisaged that a programme of meetings for staff would be set for the New Year throughout NHS Greater Glasgow.

Mr P Hamilton confirmed that leaflets had been widely distributed to a database (of now over 1,000 recipients) on Tuesday 11 November 2003. A series of seven leaflets was now available. A copy of "Health News" would be distributed with the Daily Record on 9 December 2003 and the "Staff News" had devoted five pages to the consultation. Two open space events had been scheduled as follows:

- A public session scheduled for Tuesday 20 January 2004 at the Radison SAS Hotel on Argyle Street.

- A staff session – date and venue to be confirmed.

A telephone line was now in place and Essentia (who were operating the telephone line) had agreed to provide the Corporate Communications Team with a weekly update report of calls. Similarly, weekly information was being provided on the website hits on Maternity Services. This information could be made available to NHS Board Members.

Ms Renfrew confirmed that an invitation had been extended to all Local Authorities (via Chief Executives) for NHS Board representatives to attend a meeting and provide further information. Furthermore, all Councillors had been sent the consultation material.

Sir John commented that he and Mr Divers would be meeting the Medical Director, Clinical Director and Nurse Director in each site over the coming weeks.

Mrs Kuenssberg hoped that the analytical work being carried would inform the decision making process and suggested that the financial modelling would be done on more than one option. Mr Divers confirmed that the programme of work being undertaken currently reflected the consultation proposals and that this would inform the decision process.

Members would be kept informed of developments on a regular basis.

NOTED

ACTION BY

(b) Item 130 "Beatson Oncology Centre – Action Plan"

Mr Divers confirmed that a request had gone to the Minister for Health and Community Care asking that he give consideration to returning the Beatson Oncology Centre to management within the North Glasgow University Hospitals NHS Trust. The NHS Board awaited the Minister's decision.

NOTED

143. SERVICE REDESIGN COMMITTEE : PROPOSED ESTABLISHMENT

A report of the Director of Planning and Community Care [Board Paper No 03/67] asked the NHS Board to confirm the Chair, proposed membership and remit for the Service Redesign Committee.

Ms Renfrew reminded the NHS Board that it had considered at its September 2003 meeting the requirement in the White Paper "Partnership for Care" to establish a Service Redesign Committee. Since then, further discussions had taken place with the key advisory groups and other interests. It was proposed that the Committee be established and meet four times each year, reporting regularly to the NHS Board on its activities.

Dr Nugent acknowledged that the suggested membership reflected a number of imperatives and that it was important to see the Committee's work adding value within NHS Greater Glasgow. Accordingly, the proposed membership had been established as a starting point and the detail of the Committee's work would come from its first couple of meetings.

Mr Goudie advised that the Trade Unions and professional organisations had considered they should be represented on this Committee. Dr Nugent welcomed these comments and would be happy to discuss this further. Similarly, Mr P Hamilton would discuss the Committee membership further with Dr Nugent particularly in relation to patient and public representatives. Dr Cowan encouraged the core group to be of a size that could maintain focus and achieve its remit. **Dr J Nugent**

In response to a question, Ms Renfrew advised that throughout NHS Scotland, she believed that a similar approach in relation to membership of Service Redesign Committees had been taken.

Sir John foresaw an impact of the work of this Committee on the formation and workings of the Community Health Partnerships and he encouraged Dr Nugent to make early connections with representatives from the Community Health Partnerships.

Ms Renfrew advised that the next step was to receive nominations from the respective Committees, NHS Trusts and staff and get first meeting organised.

DECIDED:

That the Board confirm the Chair, proposed membership and remit for the Service Redesign Committee. **Director of Planning and Community Care**

ACTION BY

144. DECONTAMINATION BUSINESS CASE

A report of the Chief Executive, Yorkhill NHS Trust [Board Paper No 03/68] asked the NHS Board to endorse the submission of the Decontamination Business Case to the Scottish Executive Health Department Capital Investment Group for consideration. Ms Hull advised that the documentation had already been discussed by NHS Board Members at the Board Seminar held on Tuesday 4 November 2003.

To assist with the timing of the submission of the Business Case to the Scottish Executive Health Department's Capital Investment Group (so that it could be considered at their November meeting), NHS Board Members agreed to approve the submission of the Business Case, subject to the NHS Board approving that action at its November meeting. The proposed scheme was included in the Capital Update Report submitted to the NHS Board meeting on 21 October 2003.

Mrs Hull reported that the SEHD Capital Investment Group had approved the submission.

Mrs Smith sought clarification around contingency plans for the replacement and maintenance of equipment. Mrs Hull agreed to check that the Capital provision had been included in the Business Case to allow for this. Mr Divers referred to the concept of a mutually supportive network of service contingency, in event of a major facility failure. This was being arranged with other Trusts in the West of Scotland and central belt to provide Glasgow's contingency requirements. Glasgow would be able to offer a reciprocal contingency of approximately 42,300 instruments per week (that was equivalent to 2.2 million instruments per annum). **Director of Finance**

Dr Nugent referred to the new GP contract which allowed for the expansion of minor surgery, increasing primary care activity. He wondered if the implications for the Decontamination Business Case could be rolled out into primary care. Mr Reid confirmed that discussions had taken place with the Scottish Centre for Infection and Environmental Health (SCIEH) to improve the infrastructure and this be taken forward across NHS Scotland.

Mr Divers also confirmed that work was ongoing in connection with decontamination implications for Glasgow Dental Hospital and School.

DECIDED:

That the NHS Board endorse the submission of the Decontamination Business Case to the Scottish Executive Health Department's Capital Investment Group for consideration. **Chief Executive, Yorkhill NHS Trust**

145. ACUTE SERVICES STRATEGY IMPLEMENTATION UPDATE ACAD PROCUREMENT – NEXT STEPS

Mrs Kuenssberg declared an interest in this item and did not take part in any discussion.

A report of the Programme Director (Acute) [Board Paper No 03/69] was submitted asking the Board to:

- Endorse the Performance Review Group's discussions on submitting to the Scottish Executive Health Department proposals to engage with a single bidder on the basis of the "Strategy for Proceeding with a Single Bidder".

ACTION BY

- Receive, from the Programme Director (Acute) an update on the progress on the ACAD procurement process.

Mr Calderwood reviewed the chronology of events in taking forward the single bidder process since the July NHS Board meeting and provided recommendations on the next steps. He referred to the external auditor's (PricewaterhouseCoopers) report – letter dated 17 October 2003 which confirmed that they were content with the process, which had resulted in a single bidder, and that the NHS Board had followed the required guidance and rules.

Mr Calderwood reported that he met with representatives of Glasgow City Council in relation to the planning for the two ACADs. He was optimistic that full Business Cases would be completed by July 2004, contractual close by October 2004 and construction commencing before the end of 2004.

It was intended that the arrangements be finalised for a paper on the Final Invitation to Tender and Negotiate to be considered at the 16 December 2003 Board meeting. At the same meeting the outcome of the Tender process for the Beatson Oncology Centre would also be considered. Three design companies had been short-listed and it was anticipated the proposals could be delivered within the financial framework and planned for already.

In response to a question from Councillor Duncan regarding the scope of the Victoria ACAD project to include sixty inpatient beds, Mr Calderwood advised that it was always the intention to replace the Mansionhouse Unit rehabilitation beds as part of the ACAD development. The final configuration at the Stobhill ACAD was similar with 90 rehabilitation beds already developed on that site. The clinical model would, therefore, be the same for both campuses.

DECIDED:

- That the Performance Review Group's discussions on submitting to the Scottish Executive Health Department proposals to engage with a single bidder on the basis of the "Strategy for Proceeding with a Single Bidder" be endorsed. **Programme Director (Acute)**

- That the update on the progress on the ACAD procurement process be noted. **Programme Director (Acute)**

- That the December NHS Board meeting consider the final Invitation to Tender and Negotiate for the two ACADs and the outcome of the tender process for the Beatson Oncology Centre. **Programme Director (Acute)**

146. PRIMARY CARE ACCESS STRATEGY – UPDATE REPORT

A report of the Chief Executive, Greater Glasgow Primary Care NHS Trust [Board Paper No 03/70] asked the Board to consider the progress made in achieving the 48 hour access strategy and endorse the further actions outlined.

Mr Reid referred to the Primary Care Access Strategy – the aim of which was to improve access to services across a range of measures and at the same time support the short-term goal of ensuring that patients could access an appropriate member of the primary care team in no more than 48 hours. Contact was defined as face to face, telephone or email communication between the patient and a primary care professional. The target, which was included in the quality and outcomes framework of the new GMS contract, applied to access to primary care services for routine purposes as any patient with an urgent requirement would be able to see the appropriate healthcare professional within 24 hours.

ACTION BY

Mr Reid outlined the national performance criteria and highlighted a summary of the progress to date along with an overview of the Trust's performance against the national criteria.

In response to a question from Sir John, Mr Reid advised that the new GMS contract was to be implemented on 1 April 2004 which was the same timeframe as the target for the 48 hour access strategy. It was anticipated that the two would run in parallel.

With regard to the practices who were currently not meeting the targets, Greater Glasgow Primary Care NHS Trust officers were in touch with them offering them support on how best this could be tackled and achieved.

DECIDED:

- That the progress in achieving the 48 hour access strategy be noted. **Chief Executive, Greater Glasgow Primary Care NHS Trust**

- That the further actions outlined in the report be endorsed. **Chief Executive, Greater Glasgow Primary Care NHS Trust**

147. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/71] asked the Board to note monitoring information on progress against the key national target to have no over 9 months waits from December 2003.

Ms Renfrew reported that there were currently 651 patients waiting over 9 months at the end of October 2003 with no availability status codes (ASC) applied. This represented a decrease of 123 patients (16%) on the position last month. A further comparison between the months of October 2002 and 2003 showed an improved position from 1,283 patients to 651 patients – a decrease this year of 632 patients (49%). Furthermore, there was a decrease from September 2003 to October 2003 of 774 patients to 651 patients.

Mr Davison referred to the 12,500 people on waiting lists at North Glasgow University Hospitals NHS Trust and the 419 patients waiting over 9 months – this was on target for the North Trust although it was unclear to date what the level of acute medical admission over the winter period would be – this had been identified as a risk.

Mr Calderwood echoed Mr Davison's views and confirmed that similarly, South Glasgow University Hospitals NHS Trust was on target.

Mrs Smith commended all staff involved in working towards meeting these targets particularly those involved in redesigning and re-profiling current ways of working to achieve these targets. Many initiatives had been implemented which had resulted in a marked improvement in services to patients.

Mr Divers confirmed that the winter plan was in place and additional capacity had been sought from the Golden Jubilee National Hospital and the private sector as a "buffer" for the winter in the event that in-house elective surgery had to be postponed in order to treat medical emergencies.

NOTED

ACTION BY

148. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 03/72] was submitted seeking approval of nine medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following medical practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

Dr Kathryn Sowerbutts
Dr Susan Miller
Dr Karen Palmer
Dr Veena Math
Dr Denise Graham
Dr Brian Hart
Dr Daniel Smith
Dr Claire Stevenson
Dr Mark Luty

149. PERFORMANCE REVIEW GROUP MEETING – 22 OCTOBER 2003

The Minutes from the meeting of the Performance Review Group held on Wednesday 22 October 2003 [PRG(M)03/03] were noted.

The meeting ended at 10.35 am

GGNHSB(M)03/13
Minutes: 150 - 166

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 16 December 2003 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Best
Dr H Burns
Mr R Calderwood
Mr R Cleland
Councillor D Collins
Dr B Cowan
Ms R Crocket
Mr T Davison
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie
Councillor J Handibode
Mrs W Hull
Mrs S Kuenssberg CBE (to Minute No 156)
Dr J Nugent
Mr I Reid
Mr A O Robertson OBE
Mrs E Smith
Councillor A White

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

Ms E Borland	..	Director of Health Promotion
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Ms C Renfrew	..	Director of Planning and Community Care
Professor S Smith	..	Head of Department of Obstetrics & Gynaecology, University of Cambridge
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Mr C Fergusson	..	Chair, Area Pharmaceutical Committee
Mr J Cassidy	..	Chairman, Area Nursing and Midwifery Committee
Ms G Leslie	..	Chair, Area Optometric Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

150. APOLOGIES

Apologies for absence were intimated on behalf of Councillor J Coleman, Mr P Hamilton, Mrs R Kaur Nijjar and Mr H Smith (Chair, Area Allied Health Professionals Committee).

151. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

ACTION BY

(a) A meeting had taken place on 21 November 2003 with MSPs. This had taken the form of informing MSPs of NHS Greater Glasgow health issues and ongoing Parliamentary policy regarding health matters. A number of issues had emerged and it was intended that regular meetings would be held with MSPs to ensure an ongoing two-way exchange.

(b) The Scottish Executive Health Department had approved the concept of the Centre for Population Health and Sir John had attended two meetings in connection with the ongoing development of the Centre for Population Health:

- On 21 November 2003, a meeting of the Centre of Population Health Steering Group.
- On 2 December 2003 a meeting with NHS Health Scotland – accompanied by Dr Harry Burns.

A Business Plan would now be formulated for the Centre which was anticipated to start up on 1 April 2004. An appointments process would commence soon and discussions were ongoing with Glasgow City Council regarding premises for the Centre.

NOTED

152. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following issues:

(a) The following meetings had taken place with MSPs:

- A winter planning discussion with Jean Turner MSP.
- A meeting with Jackie Baillie MSP and John McFall MP to discuss health provision in NHS Greater Glasgow.

(b) A meeting had been held on 1 December 2003 with colleagues in NHS Argyll and Clyde. This was the fifth in a series of regular meetings. Furthermore, there was now cross-representation of staff on each NHS Board's Committees which worked well in taking forward joint issues.

(c) The year-on action plan of the development of the race equality scheme had been approved.

(d) A West of Scotland community planning seminar had been held on 15 December 2003, at which over 100 delegates had attended. Mr Divers thanked Councillor White for helping stage and launch the event jointly with the Leader of East Dunbartonshire Council.

(e) Mr D Griffin, Director of Finance, Greater Glasgow Primary Care NHS Trust and Mr Divers had met with Pauline McNeill MSP and Bill Butler MSP to discuss the following issues:

- Gartnavel Hospital's campus plan.
- Green transport plan.
- Feasibility study regarding the development of a West of Scotland Cardiothoracic Unit in the Golden Jubilee National Hospital.

NOTED

ACTION BY

153. MINUTES

On the motion of Mr A Robertson, seconded by Dr J Nugent, the Minutes of the meeting of the NHS Board held on Tuesday, 18 November 2003 [GGNHSB(M)03/12] were approved as an accurate record and signed by the Chairman.

154. MATTERS ARISING

(a) The Rolling Action List of Matters Arising was circulated and noted.

NOTED

155. IMPLEMENTATION OF ACUTE SERVICES STRATEGY

(a) Emerging Pressures in Acute Services

A report of the Medical Director [Board Paper No 03/73a] asked the NHS Board to consider the issues raised in connection with emerging pressures in acute services and agree to receive a further report in February 2004.

Dr Cowan set out the proposals, from March 2000, for significant change in NHS Greater Glasgow and the key drivers behind these proposals. Following a process of planning and clinical and public debate, the Minister of Health and Community Care had approved proposals to reshape acute services with a major programme of capital investment in the period to 2012. A number of significant issues now created major challenges to sustain the current pattern of services for the timescales envisaged in the Acute Services Review. None of the issues, however, suggested a pattern of provision outside the framework agreed by the Minister.

Dr Cowan described the most significant problems and pressures currently facing NHS Greater Glasgow:

- New Deal for Junior Doctors
- Consultant contract
- SIMAP (European Court ruling about doctors' hours in hospital)
- Modernising medical careers
- European Working Time Directives
- Capacity

In particular, particular pressure was seen in the following services:

Stobhill – casualty, anaesthesia and general surgery

South Glasgow – surgery and trauma, Accident and Emergency, anaesthesia and intensive care.

ACTION BY

These factors were not unique to NHS Greater Glasgow and Dr Cowan briefly outlined the position in other health care systems including NHS Lothian, NHS Argyll and Clyde and NHS Lanarkshire.

It was important to establish an open and transparent process to properly explore and debate the impact of these problems and pressures. It would be particularly important to engage a wide range of clinical and other staff interests in that debate and also ensure appropriate political and public briefing.

Dr Cowan re-iterated the importance in carefully considering the available options to provide safe and sustainable services whilst also reviewing whether the present organisational and clinical leadership arrangements were best organised to enable these major challenges to be tackled.

Mr Divers confirmed that the emerging pressures in acute services had been shared with the Minister of Health and Community Care to be considered in the context of national policy.

In response to a question from Sir John, Dr Cowan described the working implications resulting from the new Consultant contract and SIMAP. SIMAP would result in all time spent in the workplace being counted as working hours from August 2004. This would be a maximum of 56 hours for all junior doctors (hours spent sleeping during 'on call' periods would be included in this). The new Consultant contract, to be introduced from April 2004, would require Consultants working ten, four hour sessions with a maximum of two further four hour sessions. Consultants would be required to have in place a job plan, time sheets and diary radically changing how Consultants undertook their workload. Given the change to junior doctors hours, the on-call commitment required of many Consultants had been affected.

Sir John confirmed that both the North and South Monitoring Groups had been informed of the problems of these emerging pressures and had been asked to work with the NHS Board to look at how they could best be addressed.

In response to a question from Dr Nugent, Dr Cowan acknowledged the work that could be achieved by looking at service redesign and new ways of working. It was not simply a case of employing more doctors as they were a scarce commodity particularly when their training involved five years at University and a further six years post graduate. Mrs Kuenssberg sympathised with this and encouraged the NHS Board to build even better relationships with the education systems in NHS Greater Glasgow's area in order to produce qualified staff.

In NHS Greater Glasgow there were six adult acute centres and the preference would be to reduce the number of sites but keep the same number of specialties which would allow staff to enhance their skills base as they would see enough varying types of patients and conditions. The scarcity of professional staff was a UK-wide problem.

Junior Doctors would be required to keep complex diaries and every six months, a two week period would be strictly audited. Furthermore, IT was being used to construct rotas and the IT system currently being used in NHS Greater Glasgow was the same as that accessed by the Department of Health in England.

Ms Crocket re-iterated that there was a lot of activity ongoing currently within NHS Greater Glasgow to comply with the new Junior Doctors Hours and exploring how other professions such as nurses and Allied Health Professions could help in particular areas.

ACTION BY

Dr Cowan described how the implications of the pressures had been tougher and sooner than originally anticipated.

DECIDED:

- That the issues raised in connection with the emerging pressures in acute services be noted. **Medical Director**

- That a further report be submitted to the NHS Board in February 2004. **Medical Director**

(b) The Outcome of the Tender Process for the Beatson Oncology Centre

A report of the Chief Executive, Greater Glasgow NHS Board [Board Paper No 03/73(b)] asked the NHS Board to:

(i) Receive the report on the Phase II Redevelopment of the Beatson Oncology Centre.

(ii) Note that both the capital and associated revenue costs for the project were within the sums previously agreed by the Health Department and West of Scotland Boards.

(iii) Authorise the acceptance of the tender from the preferred bidder, subject to final approval of the full business case by the Health Department's Capital Investment Group.

The second phase of the redevelopment of the Beatson Oncology Centre at Gartnavel General Hospital was one of the three early priorities for action in implementing the NHS Board's Acute Services Plan. The project would replace and enhance substantially the facilities and services which were currently provided in the Beatson Oncology Centre within the Western Infirmary.

Developed alongside and linked to the first phase of the redevelopment already completed at Gartnavel Hospital (The Tom Wheldon Building), the second phase of the project would deliver a single site, integrated tertiary cancer care centre for the West of Scotland. This specialist Centre would work in a West of Scotland network with the Cancer Unit Services developed in each of the West of Scotland NHS Board areas.

Mr Divers described the process for approval of the project and that the Scottish Executive Health Department's Capital Investment Group had approved the initial Outline Business Case in January 2002.

The project, including contractor's tender prices, matched the capital sum available and was in line with the original revenue sum proposed. The capital cost limit of £86.67M, therefore, including the contractor's cost for construction, fees and contingency of £60.337M, had been met.

The revised revenue requirement calculated on the overall capital sum of £86.67M was £7.7M. The reduction from the higher revenue estimate presented to West of Scotland Board Chief Executives in January 2003, stemmed largely from the standardisation in the interim of the application of capital charges, from the previous figure of 6% to the current figure of 3.5%. The maximum revenue contribution which NHS Greater Glasgow would require to meet, at 52.2% of the share of the extra costs, would be £4.04M, a figure which was just £40,000 higher than the estimate of £4M originally contained within the Board's Acute Services Plan.

ACTION BY

Mr Divers outlined some of the financial risks associated with the project which would require careful management and monitoring:

(i) Although the contractor's capital cost included a revised risk schedule, strict capital cost control would be required throughout the project, including the control of equipment costs.

(ii) Ongoing dialogue among West of Scotland NHS Boards would be necessary in relation to the funding of future increases in workload undertaken by the Beatson Oncology Centre, as both the Outline business Case and Full Business Case explicitly excluded this factor.

(iii) The calculations of affordability assumed a six month transfer period of services into the new Centre but excluded any additional requirement which might arise to use the vacated buildings for other purposes.

Each of these risks would be the subject of vigorous monitoring and review in the period ahead but none of them was judged to have a material impact on the assessment of affordability presented for the Phase II redevelopment.

Sir John confirmed that annual discussions would take place with West of Scotland NHS Boards to reflect the Specialist Oncologist plan for the West of Scotland pattern of cancer provision locally. To that end, Professor Alan Rodger, Medical Director, Beatson Oncology Centre, participated in all the cancer groups in the West of Scotland NHS Boards.

In response to a question from Mr Robertson, Mr Calderwood confirmed that the financial strengths of the bidder had been checked and all contractual terms had been clarified. This related to all three shortlisted consortia. Furthermore, an agreement had been reached whereby the arrangement was to build to cost.

DECIDED:

(i) That the report on the Phase II Redevelopment of the Beatson Oncology Centre be received. **Chief Executive**

(ii) That both the capital and associated revenue costs for the project were within the sums previously agreed by the Health Department and West of Scotland Boards be noted. **Chief Executive**

(iii) That the acceptance of the tender from the preferred bidder be authorised once confirmation of funding from the other West of Scotland NHS Boards had been agreed and formal Scottish Executive Health Department approval confirmed. **Chief Executive**

156. OUTCOME OF CONSULTATION ON NHS WHITE PAPER : "PARTNERSHIP FOR CARE"

A report of the Chief Executive, Greater Glasgow NHS Board [Board Paper No 03/74] asked the NHS Board to:

- Receive and consider the comments submitted by the consultees on "Partnership for Care".

- Ask the Minister for Health and Community Care to dissolve the four existing NHS Trusts to be replaced by four Operating Divisions on 1 April 2004.

ACTION BY

- Note that a separate consultation paper on the Development of Community Health Partnerships would be brought to the NHS Board for approval at its meeting in January 2004.

- Note that a fully detailed Scheme of Delegation would be brought to the NHS Board in February 2004, allowing a period of further discussion prior to its finalisation in April 2004.

Thirty-four responses had been received to the consultation and Mr Divers highlighted the key issues arising being built around the following key themes:

(i) The dissolution of the four existing NHS Trusts and their replacement with four Operating Division.

(ii) The importance of enhancing leadership and the contribution of clinical leadership in Greater Glasgow.

(iii) The move within NHS Greater Glasgow to a single employer and a single system.

(iv) The development of Community Health Partnerships.

(v) The development of a clear Scheme of Delegation as part of the move to "single system" working.

Ms Renfrew referred to the responses received in relation to the development of Community Health Partnerships and summarised the key points received so far including:

- All FHS practitioners had been supportive of the concept and were keen to be involved.

- Primary Care should be at the heart of the development of Community Health Partnerships.

- A locality focus should be retained.

It was recognised that the development of Community Health Partnerships would be the subject of a separate consultation with a paper being considered at the NHS Board in January 2004. Thereafter, a three month period of consultation would ensue with a final paper returning to the NHS Board in the Spring of 2004. It was expected that the effective date of operation for Community Health Partnerships would be 1 April 2005.

Mr Reid referred to this process and was encouraged that the NHS Board would discuss further Community Health Partnerships at its January 2004 meeting when some robust proposals could be considered.

Mr Goudie referred to the draft Scheme of Delegation which must accompany the move to single system working. This was helpful particularly as although there was no change for staff, the five NHS Greater Glasgow Chief Executives would become one NHS Greater Glasgow Chief Executive with four Divisional Chief Executives.

ACTION BY

Councillor Collins welcomed further discussion around the Scheme of Delegation as it was important this was not just a change of name for NHS Greater Glasgow. He encouraged the NHS Board to have a joint seminar for all Local Authorities particularly in taking forward the development of Community Health Partnerships as although they would all be different shapes and sizes, there would be common areas of good practice which could be built upon. Mr Divers agreed to pursue this matter further with Councillor Collins regarding the timing of such a seminar. Sir John emphasised that the exercise would not be a case of rebadging names but would be a challenge to the NHS Board in taking forward a new single vision recognising the needs of constituent parts.

DECIDED:

- The comments submitted by consultees on "Partnership for Care" be received and considered. — **Chief Executive**
- The Minister for Health and Community Care be asked to dissolve the four existing NHS Trusts to be replaced by four Operating Divisions on 1 April 2004. — **Chief Executive**
- A separate consultation paper on the Development of Community Health Partnerships be brought to the NHS Board for approval at its January 2004 meeting. — **Director of Planning and Community Care**
- A detailed Scheme of Delegation be brought to the NHS Board meeting in early 2004, allowing a period of further discussion prior to its finalisation in April 2004. — **Chief Executive**

157. A SEXUAL HEALTH AND RELATIONSHIPS STRATEGY

A report of the Director of Planning and Community Care [Board Paper No 03/75] asked the NHS Board to note the Sexual Health and Relationships Strategy for consultation and agree the proposed process to respond.

Ms Renfrew summarised the key points and recommendations contained in the summary document and described NHS Greater Glasgow's position. The strategy was very welcome in providing a national umbrella and direction within which further local change and development could be pursued in its holistic focus on sexual well-being.

It was an important strategy with broad coverage of a number of health service, health improvement and social justice issues all of which would concern NHS Greater Glasgow. As such, it was important to generate a comprehensive response to the consultation and it was proposed that the Sexual Health Planning and Implementation Group develop and lead a process to ensure such a response was submitted prior to the closing date of 27 February 2004.

DECIDED:

- That the Sexual Health and Relationships Strategy be noted. — **Director of Planning and Community Care**
- That the proposed process for responding to the consultation be agreed. — **Director of Planning and Community Care**

ACTION BY

158. MENTAL HEALTH SERVICES : ARGYLL AND CLYDE

A report of the Director of Planning and Community Care [Board Paper No 03/76] asked the NHS Board to agree, in principle, the proposed partnership arrangements for mental health services in Lomond.

Ms Renfrew outlined the proposals for NHS Greater Glasgow to manage adult mental health services to the population of Lomond. She highlighted the reasons for this approach and proposed accountability arrangements to ensure continuing local engagement. This proposed partnership for mental health services was the first which had emerged from improved joint working with Argyll and Clyde and was likely to be followed by other examples of joint arrangements where these could sustain a local service.

Councillor White referred to the discussions that took place in getting to this point and thanked Catriona Renfrew and her staff for all the work and effort put into taking forward this joint futures and partnership approach. Given that service users would be involved in taking forward the arrangements, he encouraged carers to also be consulted and perhaps be represented on the Partnership Board and Advocacy Group.

Mr Robertson agreed with this point and confirmed that Greater Glasgow Primary Care NHS Trust had been working with a Carer Strategy Group whom he would encourage to get involved.

Ms Renfrew extended her appreciation to the West Sector General Manager and his team for taking forward much of the work in relation to these proposals.

In response to a question from Mr Goudie, Ms Renfrew clarified the cross-boundary flow and monitoring systems in place to facilitate this arrangement. She confirmed that Greater Glasgow Primary Care NHS Trust would manage the budget for NHS Argyll and Clyde but NHS Argyll and Clyde was solely funding the service.

Ms Crocket referred to the current bed management system in place and the cross-charging arrangements when patients travelled to Glasgow from other areas. She was satisfied that robust monitoring arrangements were currently in place.

In response to a question from Dr Nugent, Ms Renfrew confirmed that there was a mental health inpatient ward at the Vale of Leven Hospital.

Sir John thanked all those involved in making this proposal possible and cited this as an excellent example of joint working.

DECIDED:

That the proposed partnership arrangements for mental health services in Lomond be agreed. **Director of Planning and Community Care**

159. REFORMING CHILD PROTECTION

A report of the Director of Planning and Community Care [Board Paper No 03/77] asked the NHS Board to note progress to strengthen NHS Greater Glasgow's arrangements to protect vulnerable children and respond to Scottish Executive requirements.

Ms Renfrew referred to a number of important reviews and enquiries over the last two years which had highlighted significant issues about the protection of vulnerable children and the significant NHS implications particularly:

ACTION BY

- Tackling child protection concerns where the patient was not the child.
- Sharing information with other agencies.
- Ensuring all NHS staff were aware of child protection issues.
- Ensuring clear systems to enable concerns to be raised and addressed.
- Delivering corporate leadership and commitment to child protection.

She referred to the complex set of guidance for NHS staff and work with the Local Authority Child Protection Committees to address interagency issues.

A process was in place to establish a Greater Glasgow wide NHS Child Protection Group and Ms Crocket would chair this Group on behalf of the NHS Board. Membership would include staff from all Trusts to ensure the delivery of the changes required to improve the protection of vulnerable children.

Ms Crocket confirmed that she had written to all Trust Chief Executives seeking nominations for membership of the Child Protection Group. Furthermore, she had had a meeting with Glasgow City Council representatives and had arranged similar meetings with the other Local Authority areas. She referred to pockets of excellent work currently in existence within NHS Greater Glasgow particularly within the Yorkhill Hospitals NHS Trust and Greater Glasgow Primary Care NHS Trust. It would be important to share that work across the whole NHS system. She confirmed that the Child Protection Group would set out its remit and work plan to meet the Scottish Executive Health Department's requirements, whose leadership and support would remain critical.

Councillor Collins confirmed that within East Renfrewshire Council, work was underway to address many of the issues raised and take forward joint training ventures. Similarly, Councillor White confirmed that within his Local Authority area, existing mechanisms were being reviewed with a view to improvements being made. Councillor Duncan's Council were also having in-depth discussions about this and picking up the key recommendations within the reports as a starting point to building on how to take this forward.

Ms Crocket agreed that it was important not to make this a bureaucratic process but to co-ordinate better good work that was currently being done and joint training was pivotal to this work.

DECIDED:

That the progress to strengthen the arrangements to protect vulnerable children and respond to Scottish Executive requirements be noted. **Director of Planning and Community Care**

160. 2003/04 FINANCIAL MONITORING REPORT FOR 7 MONTHS ENDED 31 OCTOBER 2003

A report of the Director of Finance [Board Paper No 03/78] updated the 2003/04 Mid Year Review presented and discussed in some detail at the November 2003 meeting of the Performance Review Group. The NHS Board was asked to confirm and endorse the following:

- That the overall financial position forecasted a deficit at the year-end of up to £10M in terms of the underlying position, albeit with some potential offset through technical accounting.

ACTION BY

- That the forecast continued to assume a further underwriting of up to £23M from, essentially, capital receipts and other "capital to revenue" transfers.

- That the measures in place within Trusts to contain expenditure would continue to the year-end and would be augmented by an ongoing review of any reserves that might be made available to offset the overall position.

- That the approach to risk management should now focus on the more radical cost recovery proposals for 2004/05 as set out in the Chief Executive's report.

Mrs Hull commented that in setting revenue budgets for 2003/04, a difficult balance had to be found between containing spending pressures being experienced within the Acute Trusts and the need to honour pre-existing investment decisions made in the Local Health Plan 2001-2006. As set out in earlier months' financial reports, the forecast outturn remained a deficit of £10M and this was over and above the £23.1M over commitment that was currently being covered non-recurrently in 2003/04 only. She summarised the best and worst cases year-end forecasts with the best being an estimated year-end position of £10,158,000 deficit and the worst case being £19,200,000 deficit – this would need to be carried forward to the next financial year.

In response to a question from Councillor White regarding capital to revenue transfers, Mrs Hull confirmed that there had been no change to the capital programme since it was last considered by the NHS Board.

Mrs Smith paid tribute to the Senior Management Teams of the NHS Board and Trusts who had worked hard to contain the situation. She referred to the future work to be done by the Service Redesign Committee in looking at re-engineering working patterns and the impact this may have on the NHS Board's financial position.

DECIDED:

- That the overall financial position forecasting a deficit at the year-end of up to £10M in terms of the underlying position, albeit with some potential offset through technical accounting be endorsed. **Director of Finance**

- That the forecast continued to assume a further underwriting of up to £23M from, essentially, capital receipts and other "capital to revenue" transfers be endorsed. **Director of Finance**

- That the measures in place within Trusts to contain expenditure would continue to the year-end and would be augmented by an ongoing review of any reserves that might be made available to offset the overall position be confirmed. **Director of Finance**

- That the approach to risk management should now focus on the more radical cost recovery proposals for 2004/05 as set out in the Chief Executive's report be endorsed. **Director of Finance**

161. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 03/79] provided monitoring information on the NHS Board's progress against the key national target to have no over 9 month waits from December 2003.

Ms Renfrew reported that there were currently 246 patients waiting over 9 months at the end of November 2003 with no availability status codes (ASCs) applied. This represented a decrease of 405 (62%) on the position last month. A further comparison between the months of November 2002 and 2003 showed an improved position from 1,118 patients to 246 patients – a decrease this year of 872 (78%).

ACTION BY

Ms Renfrew confirmed that the national target would be delivered but that the challenge was in the sustainability of this.

Mr Cleland commended the tremendous amount of work undertaken across NHS Greater Glasgow to achieve this target.

NOTED

162. QUARTERLY REPORTS ON COMPLAINTS : JULY – SEPTEMBER 2003

A report of the Head of Board Administration and Trust Chief Executives [Board Paper No 03/80] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow for the period 1 July to 30 September 2003.

Mr Best referred to Yorkhill Trust's disappointing performance in responding to only 39% of written Local Resolution complaints within 20 working days of receipt. He explained that this was due to the very often difficult and complex cases received at Yorkhill Hospital which made the timescales harder to meet. This was often further compounded by having to seek the consent of parents if the complaint was made outwith the family or by an MSP. It was agreed this should be made clear in future reports from Yorkhill Hospital.

Mr Hamilton referred to the anticipated new NHS Complaints Procedure and confirmed that he had already met with the Complaints Officers within NHS Greater Glasgow to discuss the new arrangements. A further meeting had been planned for the turn of the year to prepare new local procedures, guidance and training in line with the new proposals from the Scottish Executive Health Department.

In relation to the changing roles of Health Councils, it may be the case that the NHS Board would be required to commission advocacy services to help complainants take forward their complaints through the NHS complaints procedure.

Mrs Smith referred to the inconsistency across NHS Scotland in relation to patient consent requirements when MSPs sought information. Mr Hamilton agreed to report this back to the next meeting of the Scottish Complaints Association as patient consent should be sought nationally when MSPs seek information on behalf of patients. On this point, Dr Burns referred to a current consultation exercise regarding open access to MSPs which would change the statutory instrument to allow MSPs to seek information without seeking a patient's approval.

DECIDED:

That the quarterly report on NHS complaints in Greater Glasgow for the period 1 July to 30 September 2003 be noted. **Head of Board Administration**

163. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 03/81] was submitted seeking approval of two Medical Practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984.

DECIDED:

That the following Medical Practitioners be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984: **Director of Public Health**

ACTION BY

Dr Adam Brodie
Dr Perminder Sihra

164. PERFORMANCE REVIEW GROUP MINUTES – 18 NOVEMBER 2003

The Minutes from the Performance Review Group held on Tuesday 18 November 2003 [PRG(M)03/04] were noted.

165. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES – 28 OCTOBER 2003

The Minutes of the meeting of the Health and Clinical Governance Committee held on Tuesday 28 October 2003 [HCGC(M)03/4] were noted.

166. ANY OTHER BUSINESS

(i) Merry Christmas and a Happy New Year

Sir John wished all NHS Board Members and those in attendance a very merry Christmas and best wishes for 2004.

The meeting ended at 11.55 am

GGNHSB(M)04/2
Minutes: 14 - 28

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 17 February 2004 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Best
Dr H Burns
Mr R Calderwood
Councillor J Coleman
Dr B Cowan
Ms R Crocket
Mr T Davison
Mr T A Divers OBE
Mr W Goudie
Mr P Hamilton
Councillor J Handibode
Mrs W Hull
Mrs S Kuenssberg CBE
Dr J Nugent
Mr I Reid
Mr A O Robertson OBE
Mrs E Smith
Councillor A White

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

Ms E Borland	..	Director of Health Promotion
Ms S Gordon	..	Secretariat Manager
Professor I Greer	..	Deputy Dean, Medical School, University of Glasgow
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr D Walker	..	Assistant Director of Planning and Community Care (for Minutes 21 and 23)
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Dr B West	..	Chair, Area Medical Committee

ACTION BY

14. APOLOGIES

Apologies for absence were intimated on behalf of Mr R Cleland, Councillor D Collins, Councillor R Duncan, Mrs R K Nijjar, Professor S Smith, Mr C Fergusson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Ms G Leslie (Chair, Area Optometric Committee) and Mr H Smith (Chair, Area Allied Health Professionals Committee).

15. CHAIRMAN'S REPORT

The Chairman updated on the following events which had occurred since the last NHS Board meeting:

ACTION BY

(a) The appointment process for new NHS Board Members had been completed and a statement from the Minister of Health and Community Care was awaited.

(b) The public consultation on maternity services in NHS Greater Glasgow was drawing to a close. The NHS Board would prepare to receive and analyse in detail the responses. Members would have the opportunity to consider all issues and to seek any further information that they felt was necessary. The NHS Board's Medical Director would also provide a full account of the extensive programme of further work undertaken by the Maternity Planning Group which he chaired. Sir John would again visit all three delivery units within the near future and other NHS Board Members could request such visits if they wished. As had been emphasised throughout the consultation period, this would be a very thorough, open and transparent process. **Members**

NOTED

16. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following issues:

(a) A meeting had taken place between Sir John, Mr Cleland, Mr Davison, Mr Divers and members of the Golden Jubilee National Hospital regarding the ongoing feasibility study to develop part the Golden Jubilee National Hospital as a West of Scotland Cardiothoracic Surgery Unit. It had been agreed that further follow-up meetings be arranged to continue this dialogue.

(b) The fifth in a series of meetings with NHS Argyll and Clyde senior officers had taken place. The agenda had covered a full spectrum of issues including:

- maternity services
- adult acute medical receiving
- mental health
- Community Health Partnerships
- moving forward together with the West of Scotland Oncology Plan

NOTED

17. MINUTES

On the motion of Mr Calderwood, seconded by Dr J Nugent, the Minutes of the meeting of the NHS Board held on Tuesday, 20 January 2004 [GGNHSB(M)04/1] were approved as an accurate record and signed by the Chairman pending the following amendments:

(a) Councillor J Coleman should be added to those present.

(b) Minute 6 – Community Health Partnerships : Boundary Proposals and Principles

(i) Page 4 – paragraph 5

delete "He was also concerned about the proposed need to create mutual accountability between Community Health Partnerships and the NHS Operating Divisions for specialist NHS Services".

insert "He was also concerned about the proposed responsibilities for managing clinical pressures and delivering local service changes which could lead to an increase on community services".

(ii) Page 4 – paragraph 8 – first line

delete "16 January 2004"

insert "16 December 2003"

(c) Minute 12 – Staff Governance Minutes – 16 December 2003

third paragraph - delete "may"

insert "will"

18. MATTERS ARISING

(a) The Rolling Action List of Matters Arising was circulated and noted.

NOTED

(b) Mr Divers provided the following updates in connection with the Beatson Oncology Centre:

- The Minister of Health and Community Care had accepted the NHS Board's recommendation that full management responsibilities should rest once again with North Glasgow University Hospitals NHS Trust. Accordingly, this had now been affected.

- The Scottish Executive Health Department's Capital Investment Group had approved the Full Business Case for the £87m West of Scotland Cancer Centre at the Beatson Oncology Centre site following the support received from the West of Scotland NHS Boards and a contract for the work had now been let.

NOTED

19. MATERNITY SERVICES : ESTATES REVIEW

A report of the Director of Planning and Community Care [Board Paper No 04/6] asked the NHS Board to note a detailed report on the condition of the Queen Mother's and Southern General Maternity Units.

Ms Renfrew referred to the report which had been commissioned in June 2003 to feed into the Maternity Services Working Group. This was to ensure that there was an objective and fair appraisal of the condition and related capital cost issues in considering the closure of a maternity unit.

The estates review was reflected in the report of the Maternity Services Working Group presented to the NHS Board in October 2003 and the basis of the NHS Board's current formal consultation. The review had been circulated to all NHS Board Members in November 2003. Issues around the condition of the two maternity buildings had become a focus of public interest during the consultation process. It was, therefore, appropriate to ensure this analysis had an appropriate public profile.

ACTION BY

Mr Divers suggested that it may be helpful if the design team from Keppie Design Limited and Currie and Brown attend a future NHS Board seminar to give a presentation on their findings. Mr Best welcomed this suggestion and it was agreed this would be organised. **Chief Executive**

DECIDED:

That the detailed report on the condition of the Queen Mother's and Southern General Maternity Units be noted and that the Design Team be invited to a future NHS Board Seminar to discuss their findings. **Director of Planning and Community Care**

20. PARTNERSHIP FOR CARE : DRAFT SCHEME OF DELEGATION

A report of the Chief Executive [Board Paper No 04/7] asked the Board to consider the draft Scheme of Delegation as set out and agree that, subject to discussion and amendment, it be developed in discussion with staff partnership and other key interests with a final scheme being considered in April 2004.

Mr Divers outlined the key elements of the draft Scheme of Delegation which described the levels of responsibility of the NHS Board, the Operating Divisions and the Corporate Management Team. It proposed some further work, developed in partnership during the next two months, in order to deliver in the spring of 2004, an agreed, updated Scheme of Delegation.

He referred to the diagram on page 38 of the NHS Board papers which illustrated the key roles and responsibilities of each element of the NHS Board's unified system of working. This diagram set out layered responsibilities in the context of the collectivism of the Corporate Management Team and would most likely change as Community Health Partnerships developed, with their substantive responsibilities for health improvement, planning and partnership.

In order to help shape the governance arrangements within single system working, Members of the Audit Committees within NHS Greater Glasgow had explored the options for the future in three workshops with PricewaterhouseCoopers, the external auditors and Deloitte and Touche, the internal auditors. The key principles adopted were that there must be clear lines of accountability and that robust governance arrangements be in place within the Operating Divisions. It was recognised that the arrangements must meet the needs of NHS Greater Glasgow, reflecting the size of the new combined organisation and take account of the availability of NHS Board Members to participate in structures devised.

Mr Divers described the draft Financial Scheme of Delegation and draft Human Resources Scheme of Delegation. Both had currently in existence detailed policies and procedures and Mr Divers emphasised the need to the move to a single employer ensuring fairness and consistency of people management policy and practice on a pan Glasgow basis, underpinned by the principles of partnership working. It was, therefore, proposed that a detailed review be undertaken in partnership of these key policies and procedures in order to ensure that the Scheme of Delegation finalised in the spring was underpinned by partnership agreement of any procedures which required amendment.

It was proposed that formal meetings of the NHS Board and of the Performance Review Group be held on alternate months on a two-monthly cycle. Additionally, an extra NHS Board meeting would be held in July for the purpose of receiving the Annual Accounts, with arrangements continuing also to hold a public Annual General Meeting in November.

ACTION BY

In addition to those eight NHS Board meetings/events, it was proposed two further "open" meetings be held in the course of the year. It would remain open to the Chairman to call any further meetings of the NHS Board which were required in addition to this proposed cycle of meetings. It would similarly be open to the Chair of the Performance Review Group to arrange any additional meetings which that Group felt were required.

Sir John referred to the expected announcement from the Minister of Health and Community Care in relation to the appointment of new NHS Board Members. He, therefore, anticipated new Members being involved in the process of working towards single system working.

In response to a question from Mrs Kuenssberg, Mr Divers confirmed that the Staff Governance Committee had been subsumed under the "risk and governance" heading. Ms Kuenssberg emphasised the need to consolidate the work of Clinical Governance Committees across the four Trusts to ensure the learning of good practice in a consistent way. She welcomed the role of a designated Director of Human Resources which would add strength and control across the function providing professional advice to the NHS Board. With regard to the future NHS Board agendas, she suggested that these be constructed and tailored to meet the needs of the public audience as this was a real opportunity to take messages to the community.

Mr Robertson welcomed the proposed business cycle and the intention to appoint a designated Director of Human Resources. He commented that further work needed to be done to ensure the NHS Board's and Trusts' Directors of Finance worked effectively in ensuring a seamless transfer to single system working. The diagram on page 38 of the NHS Board papers needed to reflect new ways of working and he emphasised the need for the Chief Executives of the Operating Divisions and the NHS Board Directors to work as a coherent management team and think how best the NHS system across Greater Glasgow could be driven forward. He suggested the inclusion of an additional sentence to the second recommendation about the NHS Board and Trust Chief Executives being committed to the Scheme of Delegation, continuing to work to the present structure until a developed transitional plan was introduced to ensure a seamless transfer to single system working. Mr Robertson also wanted to see the Committee structure and how the Pharmacy Practice Committee and Reference Committee fitted in.

Mrs Smith welcomed the post of a designated Director of Human Resources to strengthen the function for NHS Greater Glasgow's 33,000 employees. She sought further clarity around the interdependent nature of the Audit, Risk and Governance Committees and how they would be linked in the future and communicate with each other. She was keen to see greater emphasis on managing risk. She applauded the suggestion of greater engagement with members of the public and patients and the proposal to hold more open type NHS Board meetings.

Dr Nugent welcomed the proposed NHS Board's business cycle and asked that the NHS Board think about training and development issues for Non Executive Members especially the Chairs of the new Divisions.

Mr Goudie described how the Scheme of Delegation could afford the NHS Board the opportunity to look at the composition and function of the Area Partnership Forum in taking forward the NHS Board's partnership working in the future.

Mr Divers confirmed that the issues raised would be taken on board and a finalised Scheme of Delegation would be considered at the April 2004 NHS Board meeting. He welcomed any further suggestions from NHS Board Members on how the NHS Board could operate more effectively. **Members**

ACTION BY

DECIDED:

(i) That the draft Scheme of Delegation be noted. **Chief Executive**

(ii) That the draft Scheme, subject to the suggestions above, be developed in discussion with staff partnership and other key interests such that a final Scheme could be brought for decision in April 2004. **Chief Executive**

(iii) That a transition plan be developed to take account of the main themes to be considered in moving to single system working. **Chief Executive**

21. NHS QUALITY IMPROVEMENT SCOTLAND : REVIEW OF PHYSICAL DISABILITY SERVICES IN NHS GREATER GLASGOW

A report of the Director of Planning and Community Care [Board Paper No 04/8] detailed NHS Greater Glasgow's response to the main recommendations of the NHS Quality Improvement Scotland (NHS QIS) review of physical disability services in NHS Greater Glasgow.

The Chairman welcomed Mr D Walker, Assistant Director of Planning and Community Care to present this paper.

Mr Walker advised that NHS QIS visited health services for children and adults (under 65 years) with physical disabilities in NHS Greater Glasgow in March 2003. This was a follow-up to an earlier visit in August 2000 by the Scottish Health Advisory Service, now part of NHS QIS.

Their visit took place over three days (3 to 5 March 2003) with a team of nine reviewers visiting over thirty different service areas involving in excess of fifty separate meetings. Their final report was published in June 2003 and made seven key recommendations of which six were relevant to NHS Greater Glasgow highlighting important issues for improving service provision.

Mr Walker led the NHS Board through the seven recommendations and remarked that the NHS QIS review process had been a helpful mechanism to highlight good practice and areas for further development. This work sat alongside the development of the draft Glasgow Adult Physical Disability Strategic Framework and actions identified would be pulled into this process. Many aspects of the recommendations were process orientated and were currently being addressed through appropriate planning and operational arenas. Other recommendations such as advocacy, wheelchair provision and repair, and acquired brain injury developments would require investment with bids being made through the 2004/05 local health planning process.

In response to a question from Councillor Handibode, Mr Walker confirmed that South Lanarkshire Council had indeed been involved with the NHS QIS visit. Despite the size and complexity of services within NHS Greater Glasgow, NHS QIS allocated the same length of time for the visit to NHS Greater Glasgow as it would to any other NHS area within Scotland.

Mr Goudie sought clarification around services for people with acquired brain injury and it was confirmed that there was now a more co-ordinated care plan approach for this patient group particularly with regard to their placements.

Mr Reid emphasised the key areas of work needing addressed particularly with regard to integration and exploring further modelling to meet the joint futures agenda.

ACTION BY

Sir John saw opportunities for the NHS and Local Authorities to work with education establishments and noted that NHS QIS had not visited any educational establishment. Colleges and Universities were important players in taking forward health and social care and time should be devoted to how further work could be done with these key partners.

Mr Robertson welcomed the recommendations which cut across a whole range of interests. Accordingly, he suggested an amendment to the recommendation which sought inclusion of an acknowledgement of the joint strands of work which required to be brought together. This was agreed. **Director of Planning and Community Care**

DECIDED:

That the recommendation made by NHS QIS and the action being taken across NHS Greater Glasgow be noted and taken forward in a joint and coherent way. **Director of Planning and Community Care**

22. A BREATH OF FRESH AIR FOR SCOTLAND : TOBACCO CONTROL ACTION PLAN

A report of the Acting Director of Health Promotion [Board Paper No 04/9] asked the NHS Board to:

- Endorse the priority being given to the prevention of smoking among young people, and through the Joint Health Improvement Plan (JHIP) process seek further support for the expansion of the Smoke Free Me and Smoke Free Class programmes.

- Instruct officers to work with NHS Health Scotland in support of the national communications strategy and review activities aimed at young people once the results of their research was available.

- Agree the expansion of the provision of evidence based smoking cessation services, with particular focus on pregnant women and people living in disadvantaged circumstances.

- Play an exemplar role in the implementation of the Glasgow Tobacco Strategy and enlist the support of local authorities and other community planning partners to take forward a co-ordinated programme to reduce rates of smoking and the subsequent ill-health among people in Greater Glasgow.

- Play an active part in promoting the benefits of smoke free workplaces and smoke free public places.

- Establish a GGNHSB working group to develop a new tobacco policy within the strategic framework of making NHS Greater Glasgow smoke free.

- Note the new target for the reduction of smoking rates in adults and the particular challenge this poses in areas of deprivation.

- Note the expected production of the results of test purchasing pilot schemes and the provision of new enforcement protocols and, once these have been published, seek the support of Local Authority partners in their implementation.

ACTION BY

Ms Borland summarised the commitments made in a Breath of Fresh Air for Scotland – the Tobacco Control Action Plan which was issued by the Scottish Executive in January 2004. She updated the NHS Board on actions being undertaken in NHS Greater Glasgow which supported the national plan. There was an extensive programme of tobacco related work in Greater Glasgow and the Tobacco Strategy for Glasgow provided a strategic framework which set the NHS action alongside that of other community planning partners.

Mr P Hamilton welcomed the aims of the plan and noted that, at the moment, each organisation with NHS Greater Glasgow had its own smoking policy. The advent of single system working as one NHS organisation in April 2004, provided the opportunity to develop a single tobacco policy.

In response to a question from Mrs Kuenssberg, Ms Borland advised that all smoking cessation services were evaluated. This information would be gathered and a database formed to track all patients passing through the service.

The NHS Board would, thereafter be able to identify if targets were being met and furthermore target further problematic areas. This would have to be seen in light of funding requirements and other competing pressures.

Ms Crocket referred to the concern at the rates of smoking among people (especially young females) where no reduction was evident. She added to this the implications of pregnant women smoking and the danger to their babies particularly in relation to them being under weight and having an increased chance of having asthma.

Dr Nugent referred to the introduction of the new GP contract which formalised the involvement of GPs in such service areas.

DECIDED:

- That the priority being given to the prevention of smoking among young people, and through the Joint Health Improvement Plan process seek further support for the expansion of the Smoke Free Me and Smoke Free Class programmes be endorsed. — **Acting Director of Health Promotion**

- That officers be instructed to work with NHS Health Scotland in support of the national communications strategy and review activities aimed at young people once the results of their research is available. — **Acting Director of Health Promotion**

- That the expansion of the provision of evidence based smoking cessation services, with particular focus on pregnant women and people living in disadvantaged circumstances be agreed. — **Acting Director of Health Promotion**

- That an exemplar role be played in the implementation of the Glasgow Tobacco Strategy and the support of local authorities and other community planning partners being listed to take forward a co-ordinated programme to reduce rates of smoking and the subsequent ill-health among people in Greater Glasgow. — **Acting Director of Health Promotion**

- That an active part in promoting the benefits of smoke free workplaces and smoke free public places be played. — **Acting Director of Health Promotion**

- That a GGNHSB working group to develop a new tobacco policy within the strategic framework of making NHS Greater Glasgow smoke free be established and that it report to the NHS Board in December 2004. — **Acting Director of Health Promotion**

- That the new target for the reduction of smoking rates in adults and the particular challenge this poses in areas of deprivation be noted. — **Acting Director of Health Promotion**

ACTION BY

- That the expected production of the results of test purchasing pilot schemes and the provision of new enforcement protocols and, once these have been published, the support of Local Authority partners in their implementation be sought. **Acting Director of Health Promotion**

23. BUILDING ON SUCCESS : FUTURE DIRECTIONS FOR THE ALLIED HEALTH PROFESSIONS IN SCOTLAND

A report of the Director of Planning and Community Care [Board Paper 04/10] asked the Board to:

- Note the content of the national report and its implications for Greater Glasgow.
- Approve Annex 1 as the overall action plan to develop Allied Health Professional (AHP) services in Greater Glasgow.
- Agree to submit the action plan to the Scottish Executive.
- Receive a further update on progress in twelve months time.

Mr Walker was in attendance to present this paper which introduced the national strategy and outlined the Greater Glasgow response to the strategy's key recommendations.

Mr Walker referred to the action plan at Annex 1 of the NHS Board paper which focussed on the principal actions necessary to advance the aims of the national target set in the context of local circumstances. An Implementation Steering Group had been established with representation from the NHS Board, each of the Trusts, AHP and other relevant professions, the AHP Advisory Committee, as well as the Local Health Council, higher education and the Area Partnership Forum. Additionally, contact had been made with each of the six Local Authorities. Mr Walker led the NHS Board through Annex 1 which included:

- Improving Health
- New Models of Care
- Service Redesign
- Clinical Governance, Research and Development
- Career Pathways, Continuing Personal Development
- Recruitment and Retention

While recognising the partnership approach required to take this forward, there was much that could be driven forward at a Greater Glasgow level and the core elements of the proposed approach in Greater Glasgow were:

- Transformation of culture
- Integrated, partnership, inter-agency and cross-boundary working
- Promoting universal high quality service and practice
- Professional development and leadership
- Better informed and knowledgeable practitioners
- Greater influence on decision making at operational, Trust and Board levels.

As a result of implementing the action plan, there would be resource consequences which had not yet been fully quantified but would be reported within the next 12 months.

Mr Reid referred to an opportunity to directly influence local colleges and universities with a view to targeting the workforce to what was required locally. Investment should also be made with the integration of further work with Local Authorities via joint community care structures building on good practice of integration.

ACTION BY

Dr Angell sought clarification around the list of Allied Health Professional staff as presented on page 57 of the NHS Board papers. He was advised that this was a Scottish Executive list and that NHS Greater Glasgow would be flexible in terms of its representatives and look at this in the context of workforce planning – this may mean additional professions being added to the list such as clinical psychologists and hospital scientists.

Mr Goudie advised that the Area Partnership Forum would be providing Mr Walker with nominations for involvement in the work of the Implementation Steering Group. **W Goudie**

Ms Crocket welcomed the work but emphasised that a link should be made into a multi-disciplinary approach to workforce planning and cross-fertilisation including retraining existing staff in other areas if their skills were considered transferable.

Mrs Hull referred to the NHS Greater Glasgow ICT Strategy and confirmed that representation would be included on the ICT Project Board to tackle current restricted access to information and to provide and maintain comparative information across the NHS Board and care groups.

DECIDED:

- That the content of the national report and its implications for Greater Glasgow be noted.
- That the overall action plan to develop Allied Health Professional services in Greater Glasgow be approved. **Director of Planning and Community Care**
- That the action plan to the Scottish Executive be agreed and submitted. **Director of Planning and Community Care**
- That a further update report on progress be received in twelve months time. **Director of Planning and Community Care**

24. 2003/04 FINANCIAL MONITORING REPORT FOR NINE MONTHS ENDED DECEMBER

A report of the Director of Finance [Board Paper No 04/11] asked the NHS Board to note the results reported for the nine months ended 31 December 2003.

The report updated the NHS Board by providing details of the financial position for the nine months ended 31 December 2003 for the Trusts and the NHS Board. A deficit of £9,695k against the break-even target was reported, an increase of £811k on the November report. The trends were shown graphically and continued to indicate a year end forecast of £10m as set out in some detail in the 2003/04 Mid Year Review.

Mrs Hull referred to the uncertainty about the financial position since the Mid Year Review as the following factors had become known:

- Back pay for part-time staff in respect of public holidays from 2000 for all part-time staff. The cost in 2003/04 could be of the order of £4m with an annual cost of £1m.
- Additional cost of Consultants' contract beyond that estimated at Mid Year Review could add a further £3m, that was, worst case forecast.
- Remaining difficulties with NHS Lanarkshire arbitration and the assumed offset against other costs on which agreement had not yet been reached.

ACTION BY

A 2004/05 allocation letter had confirmed that any in year deficit would be carried forward into 2004/05.

Mr Robertson welcomed the figures being shown as a best and worst case scenarios and the need to understand all areas of potential difficulty.

Councillor Handibode sought the inclusion to the recommendation that the NHS Board would "continue to monitor the forecast deficit position for 2003/04" and this was agreed.

Mr Davison referred to the volatility of the position for the next financial year rather than this year and referred in particular to the new Consultants' contract and its associated financial implications. This was acknowledged and there were no other factors of risk of which the NHS Board was aware at this time for 2003/04

Mrs Smith referred to the previous discussion around the Scheme of Delegation and suggested the development of a risk analysis template to analysise areas where there was not certainty.

DECIDED:

- That the NHS Board continue to monitor the forecast deficit position for 2003/04. **Director of Finance**

- That any deficit at the year end would be first call on non recurrent funding in 2004/05 be noted. **Director of Finance**

25. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 04/12] asked Members to note progress on meeting waiting time targets.

At the January 2004 meeting, the NHS Board noted the national targets that now needed to be addressed were:

- No inpatient/day case waits in excess of 6 months to be achieved by December 2005.

- No outpatient waits in excess of 26 weeks to be achieved by December 2005.

- To continue to deliver and sustain all existing targets and guarantees.

Accordingly, it was proposed that the reporting format for monitoring over 9 month waits to 6 to 9 month waits for inpatients and day cases be changed. As before, this would be presented separately for residents without Availability Status Codes and those with Availability Status Codes. Over the coming months, this would be developed further to include outpatients and performance against the targets as set out in the NHS Board's plans for 2004/05.

It was considered that sustaining the 9 month maximum wait guarantee was a major challenge as was the move towards delivering a 6 month maximum wait in a constrained resource environment.

In conjunction with the Trusts, the NHS Board was now preparing its plans for incremental performance improvement in waiting times in 2004/05, towards achieving the December 2005 targets.

ACTION BY

The NHS Board had been allocated non recurrent funding of £1.4m to deliver additional activity, both in-house and in the private sector, by the end of March. This would allow the NHS Board to sustain the guarantee of no waits in excess of 9 months and would also allow a move towards delivering the new targets in the period to March 2004.

NOTED

26. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 04/13] asked the NHS Board to approve the following medical practitioners employed by Greater Glasgow Primary Care NHS Trust to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984:

Dr Kim Hickey
Dr Roisin Dunn

DECIDED:

That Dr Kim Hickey and Dr Roisin Dunn be approved and authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984. **Director of Public Health**

27. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES – 27 JANUARY 2004

The Minutes from the Health and Clinical Governance Committee held on Tuesday 27 January 2004 [HCGC(M)04/1] were noted.

Dr Burns referred to the discussion around risk management and the handling of serious incidents and sought the NHS Board perspective on a pan Glasgow approach to clinical risk management. The previous discussion around the Scheme of Delegation and the proposal to create a Governance Forum would be a helpful way for this work to evolve.

NOTED

28. TRANSFER OF MEDICAL ONCOLOGY INPATIENT BEDS FROM THE ST MUNGO UNIT, GLASGOW ROYAL INFIRMARY, TO THE BEATSON ONCOLOGY CENTRE

A report of the Chief Executive, North Glasgow Trust [Board Paper No 04/14] asked the NHS Board to agree that the planned transfer of medical oncology inpatient beds from the St Mungo Unit, Glasgow Royal Infirmary to the Beatson Oncology Centre be brought forward to take place with effect from 1 March 2004.

Mr Davison outlined the plan for these Medical Oncology beds which at St Mungo were used mainly for breast and colorectal patients. The reconfiguration of beds in the Beatson Oncology Centre would have these tumour types admitted to Wards G6, G7 and G10. The patient load from the seven medical oncology beds would be subsumed within the workload of G6, G7 and G10 by opening G10 one further night per week and by seeking more efficient use of all the Beatson Oncology Centre beds in line with the targets to be achieved for the opening of the new centre in 2007

ACTION BY

The move would allow the St Mungo building inpatient beds to be integrated as a single service with both patients and nurses moving between the Bone Marrow Transplant Unit on Ward 40 and support beds on Ward 41 as required. It would allow the haemato-oncology nursing expertise to be developed even further and provide the new Beatson Oncology Centre with a valuable resource of highly trained haemato-oncology nursing staff when it opened in 2007.

Mr P Hamilton recognised that the planned transfer was always part of the oncology strategy but that was on the basis of it moving to the new site at Gartnavel. He was concerned that the accommodation at Glasgow Royal Infirmary was already well populated and that patients and staff had not been consulted. Further concerns surrounded Ward G10 which he understood to be a mixed sex ward. Similarly, Mrs Bryson was concerned that although Greater Glasgow Health Council understood the need to accelerate changes on acute services, this particular element had not been subjected to consultation and the accommodation at the Beatson Oncology Centre may not be up to the standard that patients had already experienced at the St Mungo Unit.

Mr Davison responded by advising that without making such a move, a safe clinical service could not be provided to patients at the St Mungo Unit as it was unsustainable. He agreed to look into the suggestion that Ward G10 was a mixed sex ward but re-iterated that maintaining a safe clinical service must take priority. **Chief Executive, North Glasgow Trust**

Dr Cowan recognised the dilemma regarding providing safe clinical services versus public consultation and appreciated the difficult decision that had to be made. Due to the concern expressed by Members, it was agreed that prior to the urgent move, contact would be made with colleagues at Greater Glasgow Health Council to discuss the proposals. Mrs Bryson welcomed this and would take this forward with Mr Davison. **Chief Executive, North Glasgow Trust**

DECIDED:

That pending further discussion with Greater Glasgow Health Council, the planned transfer of medical oncology inpatient beds from the St Mungo Unit, Glasgow Royal Infirmary to the Beatson Oncology Centre be brought forward to take place with effect from 1 March 2004 be agreed. **Chief Executive, North Glasgow Trust**

The meeting ended at 11.35 am

GGNHSB(M)04/4
Minutes: 43 - 56

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Reid Hall, Maryhill Community Central Halls, 304 Maryhill Road, Glasgow G20 7YE on Tuesday, 20 April 2004 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Bannon MBE
Mr J Best
Dr H Burns
Mr R Calderwood
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B Cowan
Ms R Crocket
Mr T Davison
Ms R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie
Mr P Hamilton
Councillor J Handibode
Mrs W Hull
Mrs S Kuenssberg CBE
Mrs R Kaur Nijjar
Mr G McLaughlin
Mrs J Murray
Ms A Paul
Mr I Reid
Mr A O Robertson OBE
Mrs E Smith
Professor S Smith
Mrs A Stewart MBE
Councillor A White

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

Ms E Borland	..	Acting Director of Health Promotion
Ms S Gordon	..	Secretariat Manager
Mr D Griffin	..	Director of Finance, Primary Care Division (for Minute 48)
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr D Walker	..	Assistant Director of Planning and Community Care (for Minute 50)

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Ms D Paterson	..	Representative, Area Nursing & Midwifery Committee
Mr H Smith	..	Chair, Area Allied Health Professionals Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

43. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr R Groden, Mr C Fergusson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Ms Gale Leslie (Chair, Area Optometric Committee).

ACTION BY

Sir John intimated that Dr Richard Groden the new Chair of the LHCC Professional Committee had been appointed by the Minister for Health and Community Care as a replacement on the NHS Board for Dr John Nugent.

44. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following issues:

(a) Sir John, Rosslyn Crocket and he had attended an important seminar on 22 March 2004 on child protection. This had emphasised the role and responsibilities of the NHS in connection with child protection and it was envisaged that a paper would be considered at the June 2004 NHS Board meeting in this regard. **Director of Planning and Community Care**

(b) Mr Divers had been accompanied by Evelyn Borland to a development workshop at Glasgow City Council to discuss the continuing development of community planning and how this could be further shaped in the City of Glasgow.

(c) The Minister for Health and Community Care had made an announcement in Parliament endorsing the Centre for Population Health. It was anticipated that a launch would take place in the summer hosted jointly by Greater Glasgow NHS Board, Glasgow City Council and the University of Glasgow.

NOTED

45. MINUTES

On the motion of Mr R Calderwood, seconded by Councillor R Duncan, the Minutes of the meeting of the NHS Board held on Tuesday, 16 March 2004 [GGNHSB(M)04/3] were approved as an accurate record and signed by the Chairman.

46. MATTERS ARISING

The Rolling Action List of Matters Arising was circulated and noted.

NOTED

47. LOCAL HEALTH PLAN AND FINANCIAL STRATEGY

A report of the Director of Planning and Community Care and the Director of Finance [Board Paper No 04/22] asked the NHS Board to:

- Approve the update to the 2002/05 Local Health Plan.
- Confirm the proposals for the use of new monies available in 2004/05 as set out in both the Local Health Plan and in fuller detail in the annexed Director of Finance report, which thereby defined the 2004/05 Startpoint Revenue Allocation.
- Confirm the follow through into the five year Financial Plan as set out in the Report of the Director of Finance.

ACTION BY

- Receive a further detailed report on the 2004/05 Recovery Plan at the May 2004 NHS Board meeting, that would set out how the NHS Board would return to financial breakeven over the next two years.

Mr Divers introduced the paper by emphasising its importance particularly in the context of understanding clearly the period of financial pressure the NHS Board faced over the course of the next two years. He commented on the level of change required to return to a position of financial break-even and this had resulted in the need for a series of measures to be taken to ensure the Board's plans and commitments were affordable.

He emphasised that NHS Greater Glasgow was not in a unique position in re-examining its priorities but that this had been witnessed across other NHS Boards in Scotland.

Ms Renfrew outlined the background and context of the NHS Board's Local Health Plan in that it set a strategic direction for the next five years and was a product of a whole range of different planning processes. The purpose of the Board paper, however, was to focus on 2004/05 and provide a summary of key local priorities for that year and describe how national priorities would be delivered.

She described the key strategies reflected in the 2002/2005 Local Health Plan and the Financial Plan which underpinned this. It was clear that in reviewing the Plan for 2004/05, a number of significant financial issues had resulted in a major gap in making realistic provision for inflation and other pressures while continuing to honour forward commitments.

This financial context had meant that a review of all the plans and priorities for 2004/05, as set out in the 2002/05 Local Health Plan, had been undertaken. Ms Renfrew summarised the outcome of that review for each of the following spending programmes:

- Mental Health
- Child and Maternal Health
- Primary Care and Other Community Services
- Acute Services
- Other Spending Programmes

She advised that the Scottish Executive Health Department had made an additional allocation intended to reflect the additional demands on health services made by deprived populations. This "unmet need adjustment" was being made pending a more detailed review of the national funding formula and gave NHS Greater Glasgow an additional allocation in each of the next two years. It had been the Board's approach to allocate such resources to services which required development and expansion to meet the needs of deprived populations and which would otherwise have been reduced or constrained because of the financial position. Accordingly, investment in additional activity to tackle health inequalities would include the following:

- Addiction Services
- Primary Care Mental Health
- Sexual Health
- Improving Oral Health
- Reducing Smoking

Ms Renfrew outlined progress made on the Scottish Executive's national priorities including:

ACTION BY

- Improving Health
- Service Redesign and Modernisation
- Patient Focus Public Involvement
- 48 Hour Access to Primary Care
- Waiting Times for Inpatient Day Care and Outpatient Treatment
- Delayed Discharges
- Healthcare Associated Infection
- Cancer
- Coronary Heart Disease and Stroke
- Mental Health

The financial requirement set by the Scottish Executive Health Department was the requirement to achieve financial breakeven. The scale of that challenge had been highlighted and Mrs Hull described the 2004/05 Financial Plan under four headings:

- Income
- Inflation and Other Pressures and Allocations to Operating Divisions
- Revising the Local Health Plan and National Priorities
- Closing the Gap

She described the key points of context which had produced a financial challenge of around £50/60 million which must be addressed over a maximum of two years. Recognising that NHS Greater Glasgow was now one unified system, the proposals brought together measures to ensure the four Divisions could stay within their allocation – a critical challenge for 2004/05.

Mrs Hull described the proposed actions to address the Board's position within the Corporate Recovery Plan which the Corporate Management Team was developing. The detailed actions within the Plan would be expanded during the next month with the objective of ensuring that the Board had a deliverable set of proposals which would return NHS Greater Glasgow to a position of financial balance within two years. The current arrangements governing resource allocation within NHS Scotland prescribed that any year end overspend carried with it a double financial jeopardy; the forward financial plan needed to reflect both the year-on-year recurrent over commitment and a non-recurrent allocation reduction which matched the level of the previous year-end deficit.

It was particularly important to recognise that a managed and fair reduction in staffing was essential to reduce costs – focussed as far as possible on non frontline posts.

Mr Robertson re-iterated the point that financial shortfall was an NHS Scotland-wide issue and not solely within NHS Greater Glasgow. The NHS Board's Performance Review Group had worked through all the documentation particularly with regard to managing expectations and meeting national priorities whilst achieving break-even. He highlighted the table shown on page 48 of the Board papers and the outstanding recurring deficit of £36.8 million for 2004/05. In response to this, Mr Divers referred to the overall achievement made by the NHS Board so far but emphasised the need to step up the effort and flesh out other elements in the Recovery Plan to meet the recurrent gap.

Mr Goudie referred to the NHS Board's monthly waiting times report which updated NHS Greater Glasgow's performance against nationally set targets. He asked if such a performance indicator paper could be made available for the other national targets to monitor the impact of investment made by the NHS Board. Ms Renfrew confirmed that performance outcomes could be shown to the Board against national priorities and consideration would be given to the best way of presenting this.

Director of Planning and Community Care

ACTION BY

Mrs Smith agreed with the points made by Mr Robertson and recognised that savings needed to be made in a short time frame of two years. She referred to the positive work carried out by the Board particularly in relation to the planning of the two new ACAD Hospitals, addressing low pay, the new Beatson Oncology Centre and junior doctors working hours – it was important that such good work was not overlooked.

Mr P Hamilton referred to the £10million shown in the Recovery Plan proposals on page 38 of the Board papers that was West of Scotland NHS Boards' income. He asked whether NHS Greater Glasgow expected to recover this sum. Ms Renfrew referred to the cross-boundary flows between NHS systems and the legitimate issue regarding the cost of services patients received from other NHS Board areas. A process was in place with West of Scotland Boards to discuss proposals regarding the settlement of such monies – the outcome of these discussions would be considered by the Performance Review Group. It was clear that the NHS Board could not continue to provide services to residents outwith its area but recognition was given to the difficult process which had to be set to deal with this. Mr Divers further confirmed that the Scottish Executive Health Department had been involved in these discussions in terms of the delivery of regional planning.

Mr P Hamilton also referred to the £500,000 identified to reduce management costs and wondered if this was a reasonable target estimate given the move to single system working. Mrs Kuenssberg, however, urged the Board not to dilute management costs too much as they were essential to help deliver NHS services although she did recognise that any identified duplication of effort should be removed and shared services within single system working might bring further savings.

Sir John thanked the Performance Review Group for its work in preparing proposals for the NHS Board's consideration and referred to the great deal of work now to be done to achieve the targets set out in the Recovery Plan. He re-iterated the importance of the ongoing dialogue in connection with the West of Scotland income and the ongoing series of developments where the plan contained elements of services that now had to be delayed.

DECIDED:

- That the update to the 2002/05 Local Health Plan be approved. — **Director of Planning and Community Care**
- That the proposals for the use of new monies available in 2004/05, as set out in both the Local Health Plan and fuller detail in the annexed Director of Finance Report, be confirmed thereby defining the 2004/05 Startpoint Revenue Allocations. — **Director of Planning and Community Care/ Director of Finance**
- That the follow through into the five year Financial Plan as set out in the Director of Finance Report be confirmed. — **Director of Finance**
- That a further detailed report on the 2004/05 Recovery Plan be received at the May 2004 NHS Board meeting setting out how the NHS Board would return to financial breakeven over the next two years. — **Chief Executive/ Director of Planning and Community Care/Director of Finance**

48. LOCAL FORENSIC PSYCHIATRIC UNIT (LFPU) – FULL BUSINESS CASE (FBC)

Mrs S Kuenssberg declared an interest in this item and, therefore, left the room during its consideration.

ACTION BY

A report of the Chief Executive, Primary Care Division [Board Paper No 04/23] asked the NHS Board to consider the full business case (FBC) for a Local Forensic Psychiatric Unit (LFPU) to be constructed on a Greenfield site at Stobhill Hospital and approve the FBC for onward submission to the Scottish Executive.

Mr Reid introduced Mr Douglas Griffin, Director of Finance, Primary Care Division who was in attendance for this item.

Mr Reid briefly described the background to the LFPU and the processes that had taken place since July 1999 when the Scottish Executive Health Department had approved the then Greater Glasgow Primary Care NHS Trust's outline business case submission to provide a LFPU for Greater Glasgow.

The full business case proposed the provision of an LFPU by Canmore Balfour Beatty under a PFI funding arrangement. At this stage, financial values and contractual terms and conditions were regarded as firm, however, were not yet final and would remain subject to change during the period up to financial close and final agreement. As negotiations with Canmore Balfour Beatty were well advanced and now in their final phase, it was reasonable to assume that any variations to price and/or contract terms and conditions which occurred between now and financial close would be minor.

The structure of the proposed financing arrangement for the LFPU, supported by the work carried out to complete the financial appraisal of the project, led to the conclusion that the transaction would be classified as "off balance sheet". This, however, remained to be confirmed by NHS Greater Glasgow's external auditors, PricewaterhouseCoopers, who would provide written confirmation of their opinion on this on conclusion of a contract with Canmore Balfour Beatty.

Following approval by the NHS Board, the full business case would be submitted to the Scottish Executive Capital Investment Group in May 2004. Assuming that this timetable was achieved, it was anticipated that construction would commence after financial close was reached on 30 June 2004 and would be completed by March 2006, with the service becoming operational thereafter.

Mr Robertson referred to the long process in getting to this stage but the considerable milestone that had been achieved in taking this full business case forward.

In response to a question from Councillor Handibode, Mr Reid confirmed that support services (as noted on page 136 of the Board paper) would be retained in-house. Mr Griffin confirmed that hard Facilities Management (FM) services would be provided by the preferred bidder but that soft FM services would be provided in-house.

DECIDED:

- That the full business case for a Local Forensic Psychiatric Unit to be constructed on a Greenfield site at Stobhill Hospital be approved and that it be submitted to the Scottish Executive Capital Investment Group for consideration. **Chief Executive, PCD**

Mrs Kuenssberg returned to the NHS Board meeting at the conclusion of this item.

49. COMMUNITY HEALTH PARTNERSHIPS (CHPs) – OUTCOME OF CONSULTATION ON INITIAL BOUNDARY AND SERVICE PROPOSALS

A report of the Director of Planning and Community Care [Board Paper No 04/24] asked the NHS Board to:

ACTION BY

- Note the outcome of consultation.

- Approve the proposed boundaries subject to the final review outlined in the paper.

- Remit to the CHP Steering Group, the important wider issues which the consultation had raised for consideration in developing the detailed schemes of establishment, which would be submitted for Board approval.

- Confirm its commitment to the full engagement of all primary care practitioners in the migration from Local Health Care Co-operatives (LHCCs) to CHPs.

Ms Renfrew set the background for the Board's proposals for consultation stemming from the proposals within the White Paper to evolve Local Health Care Co-operatives to Community Health Partnerships. She described the consultation process and how this was managed through a wide range of mechanisms. She restated the boundary proposals put to consultation and set out responses to these proposals suggesting how the Board should now proceed.

The boundary proposals had been developed as organisational boundaries and it was not intended to disrupt natural patterns of care. As such, it was acknowledged that cross-boundary flows and their impact on services and budgets required further detailed work. It was also accepted that CHPs would have substructures within their primary boundaries to reflect different communities and neighbourhoods and the different population clusters for their varied functions.

The proposals were that there should be single CHPs covering each of the following Local Authority areas with boundaries coterminous with the Local Authority:

East Dunbartonshire	-	population 109,400
West Dunbartonshire	-	population 93,300
East Renfrewshire	-	population 90,000

For Glasgow City Council, five CHPs were proposed:

Western	-	population 138,284
Northern	-	population 115,769
Eastern	-	population 146,155
South West	-	population 114,337
South East	-	population 120,910

No proposals had been made for the Rutherglen/Cambuslang and the North Lanarkshire part of Greater Glasgow, reflecting the earlier stages of discussion with Lanarkshire NHS Board and Lanarkshire Local Authorities. It had to be questioned, however, whether the Rutherglen/Cambuslang LHCC population of around 55,000 was large enough to represent a viable CHP.

Ms Renfrew described the implications of the proposed boundaries for existing LHCC structures. It was important to recognise that key to the further development of CHPs and addressing the issues was reaching agreement on final boundaries. As such, Ms Renfrew led the Board through the proposed further elements of work intended to offer certainty to enable progress to be made. She highlighted the various concerns and issues raised with the boundary proposals and a suggested response to these.

Throughout the consultation exercise on boundaries, the opportunity was taken to include two sets of other issues about CHPs in connection with their roles in managing services, resources, staff and functions and the potential organisation and resources of CHPs.

Ms Renfrew restated the position that CHPs had massive potential to deliver better services and decisions for their population, anchored in local accountability and responsibilities which connected wider health improvement with service delivery. CHPs were not only seen as a way of better managing and integrating NHS services but also as offering an organisation which could be a partnership with Local Authorities, giving the opportunity to integrate services and drive a joint health improvement agenda.

Ms Renfrew described the consultation process as very successful in terms of attracting a wide range of thoughts and constructive responses which needed to be considered carefully. It was critical to achieve two objectives in the next phase of work:

- Firstly to ensure that there was particular effort to retain the support and engagement of health staff and those who had contributed so much to the success of LHCCs.

- Secondly to ensure the many and detailed issues raised were comprehensively worked through in the development of detailed schemes of establishment.

The CHP Steering Group and the processes established with Local Authorities would need to achieve these two objectives and the Board would want to test progress at regular intervals.

Councillor Handibode, was sympathetic to the Rutherglen/Cambuslang issue and saw many advantages of a CHP being populated with 55,000 but was not unhappy with the Board's proposal. He did, however, suggest caution in terms of the negotiation of the boundaries.

Councillor Collins referred to the further detailed discussions to take place regarding Thornliebank Health Centre which lay just outside the Glasgow City boundary but with most of its patients living in Glasgow City. As such, detailed discussions would take place with East Renfrewshire and Glasgow City Councils to establish how the practices within the Health Centre could be incorporated into a Glasgow CHP.

Councillor White welcomed the proposals and sought concentration of effort on services rather than boundaries.

In response to a question from Mr Cleland, Ms Renfrew confirmed that the Prince and Princess of Wales Hospice had been consulted and lines of communication would remain open in taking forward proposals for which CHP boundary it lay within.

Mr Robertson commended the work done throughout the consultation exercise and encouraged such commitment through to the delivery phase.

Dr Burns referred to the ongoing work being undertaken with all Local Authority partners to discuss how health improvement services could be delivered and taken forward through CHPs.

Councillor Duncan acknowledged the further work and discussion with the Anniesland, Bearsden and Milngavie practices to see how the LHCC migrated into two CHPs and how the service issues could be addressed

DECIDED:

- That the outcome of consultation be noted.

ACTION BY

- That the proposed boundaries, subject to the final review outlined in the paper be approved. **Director of Planning and Community Care**

- That the CHP Steering Group be remitted to consider the important wider issues which the consultation had raised and lead the developmental detailed schemes of establishment which would be submitted for Board approval. **Director of Planning and Community Care**

- That commitment to the full engagement of all primary care practitioners in the migration from Local Health Care Co-operatives to CHPs be confirmed. **Director of Planning and Community Care**

50. MODERNISING NHS DENTAL SERVICES IN SCOTLAND : SCOTTISH EXECUTIVE CONSULTATION PAPER

A report of the Director of Planning and Community Care [Board Paper 04/25] asked the NHS Board to agree and submit the report as a response to the Scottish Executive consultation paper.

Ms Renfrew introduced Mr David Walker, Assistant Director of Planning and Community Care, who was in attendance to present this paper.

Mr Walker, Chair of the Dental Planning Group, welcomed the opportunity to contribute to this consultation document confirming that the officers agreed with much of its analysis, principles and proposals.

It was recognised that the present General Dental Service system was no longer in tune with the realities and complexities involved in the delivery of modern dentistry and that arguably the resources were not having the correct strategic impact. Similarly, there were concerns at what was perceived to be widespread disillusionment amongst General Dental Practitioners about the current system. Consequently, the need for change was recognised but the Executive would be encouraged when implementing any new proposals to do so in concert with the profession and to phase change over time to minimise any risk of destablisation.

Mr Walker summarised the overall aims to modernise dental services including:

- Prevention.

- Access – encompassing infrastructure support, incentives in deprived areas, mixed payment methods, developing a comprehensive dental health system and workforce planning.

- Remuneration – including simplifying charges, future range of NHS dental treatments, payment, quality and clinical pathways.

- Opportunities for integrated working.

- Investment.

Dr Angell confirmed that the draft response reflected the Area Dental Committee's views and highlighted that although many dentists within NHS Greater Glasgow were dissatisfied with the current system, the area had been fortunate in that it had not suffered in terms of lack of availability of NHS dental services. In taking forward the consultation, he encouraged the Scottish Executive to be realistic particularly in relation to the remuneration for NHS dental services. Mr Walker confirmed that the Oral Health Planning and Implementation Group was looking further into this and he was hopeful that such issues would be addressed.

ACTION BY

Dr Angell also expressed his disappointment that the consultation had not included any suggestion of fluoridation in the public water supply which the Area Dental Committee would support. Dr Burns confirmed that if the public water supply included fluoridation, there was evidence to show that it would reduce dental caries with no adverse harm to the population. It was not an issue for this consultation but acknowledged that the Public Health community at large would be supportive.

In response to a question from Mr Bannon, Mr Walker confirmed that the "secondary care" referred to in paragraph 2.3 of the document did include Glasgow Dental Hospital and School.

In response to a question from Mrs Murray, Mr Walker confirmed that "Professions Complementary to Dentistry" as referred to in paragraph 3.2 of the document referred to Dental Hygienists and Dental Nurses. Dr Angell advised that Glasgow was now training Dental Therapists who could carry out many such procedures.

Ms Borland was keen that the health inequalities gap in relation to dental care was also addressed and that the supply of dentists should be evenly spread throughout NHS Greater Glasgow regardless of affluent or deprived areas.

Mrs Kuenssberg referred to the captive audience at schools and encouraged work with Education Departments to ensure that this opportunity was not missed in promoting oral health amongst children.

DECIDED:

That, subject to drafting changes, the report be agreed and submitted as a response to the Scottish Executive consultation paper. — **Director of Planning and Community Care**

51. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 04/26] asked Members to note progress on meeting waiting time targets.

Ms Renfrew referred to the changed reporting format from specifically monitoring over nine month waits, to six to nine month waits for inpatients and day cases. As before, this was presented separately for residents without availability status codes and those with availability status codes. Over the coming month, the Board would develop this further to include outpatients as well as performance against the targets. — **Director of Planning and Community Care**

It was considered that sustaining the nine month maximum wait guarantee was a major challenge. Also the move towards delivering a six month maximum wait in a constrained resource environment would be a serious problem when set alongside the outpatient target.

In conjunction with the Divisions, the Board was preparing its plans for incremental performance improvement in waiting times in 2004/05, moving towards achieving the December 2005 targets.

NOTED

ACTION BY

52. MEMBERSHIP OF THE GREATER GLASGOW HEALTH COUNCIL

A report of the Head of Board Administration and Convener of Greater Glasgow Health Council [Board Paper No 04/27] asked the Board to approve offering five Members a further 12 month extension to 31 March 2005 and to note that the remaining Health Council Members already had a term of office to 31 March 2005.

DECIDED:

- That offering the following five Members a further 12 month extension to their term office to 31 March 2005 be approved: **Head of Board Administration**

  Patricia Bryson – Convener
  Suzanne Clark
  Caroline McCalman
  Margaret McNaughton
  William May

- That the following Health Council Members already having a term of office to 31 March 2005 be noted: **Head of Board Administration**

  John McMeekin – Vice Chair
  Stewart Daniels
  Anne Jarvis
  Cynthia Mendelsohn
  Williamina Shields
  Gordon Connell
  Patricia Munro
  Maureen O'Neill

- That approval be given to the Head of Board Administration to make appointments to the seven casual vacancies which had now arisen utilising the usual methods of recruitment. **Head of Board Administration**

53. PERFORMANCE REVIEW GROUP MINUTES – 9 MARCH 2004

The Minutes of the Performance Review Group held on Tuesday 9 March 2004 [PRG(M)04/2] were noted.

NOTED

54. AUDIT COMMITTEE MINUTES – 9 MARCH 2004

The Minutes of the Audit Committee held on Tuesday 9 March 2004 [A(M)04/1] were noted.

NOTED

55. ADJOURNMENT

The NHS Board agreed to an adjournment of 30 minutes to allow Members to have lunch before the next item on the agenda.

ACTION BY

56. MODERNISING MATERNITY SERVICES : OUTCOME OF CONSULTATION

A report of the Chief Executive, Director of Planning and Community Care and Medical Director [Board Paper No 04/28] was submitted on the outcome of the consultation held on Modernising Maternity Services in NHS Greater Glasgow.

Sir John introduced the paper and commented that it was the end of a long and difficult process beginning in 1999. He outlined why it had been so difficult:

- Proposals for changes in medical service were controversial. Where change affected maternity services it was particularly sensitive. The Board recognised this and understood the strong views that had been expressed and had listened to those views in forming its decisions.

- Since 1999 there had been a strong clinical consensus about the need to move from three to two delivery units because the level of medical cover required could not be sustained – this was now an urgent issue which had to be addressed.

- There had always been conflicting clinical advice from the key medical specialties about which unit should close. Those differences being played out in the media had meant the process to arrive at a decision had been particularly difficult.

These issues could not, however, undermine the Board's primary responsibility to move to a decision and to make that decision based on the clearest and most objective appraisal of the best services for women and their babies. The Board had worked for almost a year to bring forward the proposals for a decision which aimed to meet that responsibility.

He outlined how the paper would be presented.

Mr Divers would begin by giving a brief introduction to the paper followed by three short presentations covering the consultation process, the main themes which had emerged from it and, finally, an outline of the work undertaken by the Maternity Planning Group. Following that, a broad discussion with Board Members would take place.

Introduction to the Board Paper – led by Mr Divers

Mr Divers described the context in which the Board had to make its important decision. He reminded Members about the bigger picture within which the decision about maternity units was framed. This context confirmed the Board's ability to improve maternity services in implementing the recommendations included in the Board paper in a number of ways outlined in page 229 of the Board paper. The Board paper had three substantive attachments:

- The report of the Maternity Working Group – page 257 to 283.

- An index and summary of responses to the consultation including the issues raised in public meetings – page 284 to 305

- The report of the Maternity Planning Group – page 306 to 324

He restated the background to the proposal to confirm the process the Board had followed in reaching this decision point since May 2003 and advised that Board Members had heard directly from clinicians, participated in public meetings and a number of Members had visited the maternity hospitals.

ACTION BY

Consultation Process – led by Mr Divers

Mr Divers went on to present the four key strands of process which had brought the Board to the point of decision today:

- 1999 consultation
- 2003 preconsultation
- 2003 public consultation
- 2004 decision making

He took each one in turn and described their outcomes.

1999 Consultation

Having undertaken detailed work on which unit should close, the Board concluded that maternity and children's services should be considered together as part of the ongoing Acute Services Review consultation.

There was a lack of clinical consensus about the triple co-location of maternity, children's and adult services and that process proved inconclusive.

The Board knew, however, that it would need to return to the issue of maternity services, given the clear clinical view that the present pattern was not sustainable.

2003 Preconsultation

The Board knew this would be a difficult and sensitive decision and agreed to establish a major preconsultation exercise to enable it to develop proposals for formal public consultation. In May 2003, the Board approved a process which included three strands:

- A Maternity Working Group – which would be chaired independently and include three non Executive Members. Evidence would be given to the Working Group by open sessions and the Group itself was to be supported by external clinical advisers.

- Midwifery Advice

- MATNET – the Maternity Services Users Network

2003 Public Consultation

In October 2003, the Board received, in public, the three reports and then continued on that day, in seminar discussion and concluded that the preconsultation reports should form the basis of public consultation.

A formal Board paper was prepared on that basis and the October Board meeting endorsed seven consultation proposals including the proposed closure of the Queen Mother's Hospital (QMH) but with the addition of questions designed to ensure contrary views could be freely expressed.

Alongside the public consultation process, the Board established the Maternity Planning Group to report in detail on how services could operate if the QMH closed and to address issues emerging from the consultation.

2004 Decision Making

The Board had had a number of Seminar and Board meeting discussions during the consultation process, considering emerging issues.

ACTION BY

Board Members had received a full set of 329 consultation responses, accompanied with a summary. Recent seminars had enabled Board Members to consider the detail of the Maternity Planning Group's conclusions, hear direct clinical perspectives and, on a number of occasions, to discuss the development of the structure and content of the Board paper.

Mr Divers asked Ms Renfrew to lead the Board through the themes which had emerged from consultation.

Main Themes Emerging from Consultation – led by Ms Renfrew

Ms Renfrew referred to Attachment 2 of the Board paper which summarised all the responses and issues raised at public meetings. The Board paper set out and responded to the main themes and Ms Renfrew highlighted, in particular, the Board's response to three of these themes:

- Potential rise in population – Ms Renfrew referred to the Table on page 248 which illustrated the decline in births in Greater Glasgow over the last ten years. The 2003 figure of births in Glasgow hospitals included around 700 additional births due to the closure of Vale of Leven Hospital which had now re-opened.

  To arrive at the future projections for births in Glasgow Hospitals, the Board had assumed that around 300 Greater Glasgow women would deliver outside Glasgow and around 2,000 non Greater Glasgow women would deliver within Glasgow hospitals. Both of these numbers had been stable over a number of years, since the closure of Rutherglen Maternity Hospital.

  With the Vale of Level Community Midwifery Unit re-opened, this would suggest that planning for between 11,000 and 11,500 deliveries was a prudent approach, particularly as relatively conservative assumptions about throughput in sizing the physical capacity of the two units had been made.

- Regional planning – the Board had worked closely with Lanarkshire and Argyll and Clyde NHS Boards throughout the last decade to ensure maternity plans were coherent. Lanarkshire had an established pattern of flows into its single and relatively new delivery unit at Wishaw. Argyll and Clyde concluded a major strategic review of maternity services in the middle of last year, closing two Consultant led units, at Inverclyde and Vale of Leven and consolidating services at the Royal Alexandra Hospital (RAH) in Paisley. The Board had engaged fully in that review and the only outstanding issue was the definitive assessment of how many women from the Dumbarton area would opt to deliver in Glasgow. The maximum impact of this factor was an additional 200/300 deliveries above the planned 11,200 – those numbers would not require a third delivery unit.

  The suggestion had been made that because the RAH was marginally nearer the Southern General Hospital (SGH) than the QMH that would offer a basis to close the Southern General and retain the QMH. It was difficult to see relative proximity as a definitive factor in reaching a decision. The pattern of maternity hospitals did reflect historic patterns of residence and delivery and, as always, decisions needed to be made about future services with the present pattern as a start point. The suggestion that a further regional planning exercise could result in Glasgow retaining three units could only be made on the basis that either the delivery unit at Wishaw or the RAH would close. Both served distinct populations and it was unlikely there would be support for their closure in order that Greater Glasgow could retain three units within a three mile radius of each other.

ACTION BY

- Interests of women and their babies – consideration of this proposition had a number of dimensions which suggested the status quo did not serve the best interests of women and their babies:

  - There was strong clinical consensus that three units would not provide safe and sustainable services. The Board's professional advisory committees supported the closure of one unit.

  - Retaining unused capacity had an opportunity cost in terms of resources available to other services. The vast majority of maternity care was delivered in community settings – the Board's proposition had seen that was where resources should be concentrated and would have most impact in addressing the effects of poverty and the health inequalities it created.

  - There was no evidence that the very marginal additional travelling times, no more than five minutes by blue light ambulance, represented any risk to safety, particularly when that pattern of service retained units north and south of the river, addressing the City Council's point that over reliance on cross river routes in dealing with time critical emergencies might be unwise.

There had never been an argument that the ideal arrangement for the very small numbers of neonates who needed specialist intervention was the co-location of maternity services and specialist paediatric services. The Maternity Working Group Report had stated this and the relevant policy guidance confirmed the desirability of co-location of neonatal intensive care and surgical services, achieving in utero transfer for prenatally diagnosed disorders. That ideal service arrangement could not be achieved if the Board was also to meet the imperative that major obstetric services should be alongside adult and intensive care services. Ms Renfrew re-iterated, however, that:

1. The reviews of maternal and neonatal morbidity and mortality did not appear to offer any support to the view that risks to women were theoretical and risks to neonates were substantial. The reverse was concluded by these reviews.

2. There did not appear to be any information that illustrated worse outcomes in UK children's hospitals which were not co-located with maternity services.

Maternity Planning Group – led by Dr Cowan

Dr Cowan described the work of the Maternity Planning Group which the Board had established to test its proposal to close the QMH and to address issues arising from the preconsultation and consultation . The final report of the Group described current patterns of service, how services would be organised if the QMH closed, including neonatal transfer arrangements.

The Group was chaired by Dr Cowan as the Board's Medical Director and included members from all three Divisions. Dr Cowan referred to the work of the Group having a number of different strands:

- Detailed clinical input from a range of staff across maternity, neonatal and paediatric services.

- Numeric analysis.

- Establishment of subgroups on specialist paediatrics, aspects of fetal maternal medicine and workforce.

ACTION BY

- Visits to other services that did not provide co-located maternity and specialist paediatrics.

He highlighted the main issues covered by the Group as follows:

- Consolidated fetal medicine service – there were a number of high quality, major regional services providing all that QMH did without a children's hospital alongside. These services illustrated the importance of clinical networking with the specialist children's hospital. A larger service would offer greater potential for subspecialisation and improved cover.

- Transfer arrangements – the principle which informed the Group's work was to minimise additional transfers and the report included detailed data on the current pattern of transfers. The Group suggested a second transfer ambulance to ensure that the Board could deliver expeditious transfer when it was required.

- RHSC neonatal arrangements – this was an important issue for the Group particularly as a continued neonatal intensive care unit was proposed by the Neonatal Subcommittee. It did, however, recognise this not to be viable and the need, therefore, for another safe option. Dr Cowan referred to the capital work underway to develop proposed new Intensive Therapy Unit (ITU) and High Dependency Unit (HDU) facilities alongside cardiac and surgical wards and the multi-disciplinary clinical input from surgeons, cardiologists, paediatric intensivists and neonatologists.

- National Services – the Group considered and made specific proposals on how the following national services would be sustained if the QMH closed:

  - Paediatric cardiology and cardiac surgery.

  - ECLS (Extra Corporeal Life Support)

  - Interventional fetal medicine

A further critical issue was to ensure that the pattern of referral into Glasgow of fetal abnormalities continued. It was the Group's view that this would depend on the Board's ability to ensure that the Princess Royal Maternity Hospital (PRMH)/Royal Hospital for Sick Children (RHSC) service was seen as an integrated service provided on two sites. The centres the Group visited which were not co-located reported a strong pattern of regional referral. Dr Cowan summed up by commenting that the pattern of services proposed in the consultation could be provided in a safe and sustainable way, avoiding separation of mothers and babies, increasing specialist input to SGH and PRMH services and addressing access concerns.

The Chair opened the discussion to points and questions from Board Members.

Ms Crocket re-emphasised the overarching issue of reducing from three to two delivery units. She referred to the many associated advantages of this in terms of community services development and enhanced public health midwifery services.

In response to a question from Mr Robertson about national services, Dr Cowan confirmed that the Maternity Planning Group had considered these issues in its proposed service model and had made clear proposals to ensure these services were secure, practically based on other UK centres. Discussion would continue with the National Services Division in taking these forward following a decision.

Mr P Hamilton was concerned about conflicting clinical advice with regard to transport. He confirmed to the Board the clear advice the Maternity Working Group had received from Dr Charles Skeoch's, (Regional Director of Neonatal Transport, West of Scotland), written submission made to the Maternity Working Group on 25 September 2003 *"….. we have undertaken 440 transfers since 10 March 2003 with no deaths and no major morbidity due to transfer. ……My personal view regarding the role of transport is non judgemental as regards the location of maternity services. Our service will respond to the needs of the hospitals requiring to move their infants ……. I would not like your Group to get the view that there were surgical babies dying because they cannot receive timeous surgical intervention. Transport medicine is about stabilisation and safe transport for staff and baby – not speed!"*

Mr Davison referred to the capability of the PRMH to cope with increased deliveries. Senior staff at PRMH had assessed the building in terms of space and confirmed that if the QMH closed, adequate space provision could be made available at the PRMH. Mr Davison supported co-location of adult and maternity services and, therefore, the recommendations.

Mrs Smith thanked Board officers who had provided so much information throughout the consultation period and who had supported this with a vast array of clinical information being made available. In considering the issues of morbidity and mortality at pages 242 and 243 of the Board paper, Mrs Smith referred to triple co-location as a gold standard. She commended the Yorkhill model where excellent services had been provided for 40 years but agreed that the current position was not sustainable. In such circumstances, she recognised that managing change was never easy but saw no reason for it not being managed effectively should the QMH close. She referred to the high rate of deprivation within the NHS Greater Glasgow area and the hard work being undertaken in terms of health promotion which the proposed changes would strengthen.

In response, Mr Divers referred to the clinical views on triple co-location as outlined in pages 246 and 247 of the Board papers. There was now strong clinical support for the co-location of adult, paediatric and maternity services. It was proposed that the process be put in place to bring proposals for the longer term disposition of specialist children's services to formal public consultation by the end of 2004. It should be explicit that the Board was making that commitment to bring forward those proposals based on the responses it had received from clinical staff to the consultation on maternity services.

Professor Smith agreed that maternity services should be provided in an environment where adult services were available particularly intensive care units and specialty consultant led teams – these were not available on a paediatric site. He referred to the strength of the clinical advice that consultant units should be on an adult site and that there were real, not theoretical, risks to women. He was strongly supportive of recommendations.

Mr Cleland referred to his strong personal link with Yorkhill particularly as he had been Vice Chair of the former Trust for four and half years. He was familiar with staff views, expectations and arguments and agreed that concerns should be around services and not the buildings. He supported the move from three to two delivery units and agreed that the Board should pursue the gold standard of triple co-location. He was strongly supportive of recommendation 3 that in implementing this closure there was a real need to engage the clinical staff. He confirmed that North Glasgow University Hospitals Division staff would work with the Board to take forward the new service proposals should the QMH close and set in place proposals for an enhanced service for mothers and babies.

ACTION BY

Mrs Kuenssberg offered views from a different perspective. As Chair of Yorkhill NHS Trust until the end of March 2004, she had been closely involved in this difficult debate and had a particular interest in its outcome. As a Member of the NHS Board, however, she had also tried to take a wider view and to focus on the interests of the mothers and babies whose care the Board had a responsibility to provide. She strongly supported a number of the proposals:

- The move from three to two delivery units.

- The enhancement of services in the community, the development of co-ordinated midwifery services on a Glasgow-wide basis and the idea of maternity and paediatric services being managed within the single structure across Greater Glasgow – three proposals which would have significant benefits for mothers, children and the wider family.

- That the ideal model of care would be the triple co-location of a maternity unit, a children's hospital and an adult hospital.

She was, however, consistently opposed to the proposed choice of the QMH closing, breaking the vital link between maternity services and paediatrics provided at the RHSC.

She referred to the Working Group Report presented to the Board on 7 October 2003 and, at that time, had argued that more would be lost than gained by closure of the QMH – she had not changed her view.

She referred to the Board paper where it stated repeatedly that it was the Board's responsibility to provide the safest possible services for mothers and babies. In an ideal world this would require direct access to intensive care facilities for both groups – not currently an option for Greater Glasgow. Choosing to close the QMH because of the lack of on-site adult intensive care would leave two delivery units co-located with adult services but would remove the similar advantages for babies of access to paediatric services.

Mrs Kuenssberg considered that the Board fell short of conducting an open, transparent and involving consultation process. On the basis of the Working Group Report recommending closure of the QMH, public consultation went ahead with this one option only removing any comparative element from the debate.

The lack of comparison between potential options had also prevented searching analysis of various practical aspects which would normally be fundamental elements of a strategic review. In terms of workforce issues, one of the main drivers of the review, the closure of either the QMH or the SGH would relieve pressures on some key groups.

She lastly referred to the positive element to come out of the consultation process which was the new volume of clinical support for the co-location of adult, paediatric and maternity services, described as the gold standard. In the interests of mothers and babies, NHS Greater Glasgow should not settle for less and accordingly the Board should commit to this exciting vision. She recognised that great care would be needed in formulating these proposals – to decide where this new centre should be and to tackle many issues about resourcing and timescale. She argued that commitment to this new vision for the future, fundamentally changed the context of the current debate. Decisions about the future of maternity services and children's services should take place in tandem and it was the Board's responsibility in the interim period to retain the safest and best of the existing services for mothers and babies. She considered this could be done in two complementary units – at the Princess Royal Maternity and the Queen Mother's with close networking between them.

ACTION BY

She concluded by indicating she could not support the closure of the QMH.

Sir John noted the four important themes from Mrs Kuenssberg's comments. He asked Ms Renfrew to respond to the points on risks and outcomes, Mr Divers to deal with consultation and Dr Cowan to respond to the points about the Maternity Planning Group.

Ms Renfrew responded to a number of Mrs Kuenssberg's points:

- intensive care for women and babies could be provided on one site in Glasgow – but only at the Southern General, not the QMH.

- it was wrong to suggest that there was no concrete evidence – fifty years of confidential enquiries into maternal deaths and many years of similar reviews of neonatal morbidity and mortality provided a very strong base of evidence in support of the closure of the QMH.

- While triple co-location may be the gold standard it clearly could not be delivered in a timeframe which would enable the Board to safely sustain three maternity units.

Mr Divers addressed the points about consultation. The Board had agreed to consult on the Working Group's recommendations but with a clear statement that challenges to those conclusions were entirely legitimate and questions to encourage those. Responses to consultation clearly indicated that there had been no sense of restriction on alternative views and options being put forward.

Dr Cowan responded that the Maternity Planning Group had carefully considered workforce issues and its recommendations reflected what was required. It was the Yorkhill proposal on neonatology services which would increase the pressure on staff. The Group report included financial analysis and estates issues had been reviewed in three different reports, summarised in the Board paper

Professor Smith confirmed his view that it was not clinically viable to have two consultant units with patients neatly divided between high risk mothers at the PRMH and high risk babies at the QMH. There was no credible clinical advice which would support such a proposition.

Ms Dhir indicated she had thoroughly reviewed all of the evidence, responses and advice with fresh and objective eyes and had concluded the opposite of Mrs Kuenssberg and that the closure of the QMH was the right decision. She also referred to the whole host of community based maternity services which were being enhanced and agreed that a better service provision would be provided if the QMH was to close.

Councillor Collins respected the views of all NHS Board Members and commended Board officers for the time and effort put into presenting the vast array of information. He was keen that the Board Members respect collective responsibility for any decision made.

ACTION BY

Councillor White supported the points made by Mrs Kuenssberg and agreed that the gold standard was triple co-location. It had been a lengthy and detailed process and he had read all responses and visited both maternity units. He opposed closure of the QMH on the basis that more was to be lost than gained. He referred to the clinical excellence provided at Yorkhill, made only possible with the co-location of the QMH and RHSC. He did not believe that the regional planning discussions had been adequate and made reference to the "Minority Report" issued yesterday by members of Yorkhill Staff Association within the Maternity Planning Group exercise. He suggested that the decision be suspended until further work and feasibility be undertaken on the proposal for triple co-location. It had gained strong clinical support and there was no public support for the closure of the QMH.

Mrs Bryson conveyed the views of Greater Glasgow Health Council who agreed that the status quo was not sustainable. The Health Council also considered that information should have been made available on the finance and estate elements of the proposals.

Mr Goudie acknowledged the considerable body of work and the huge effort involved. The Board must recognise, however, that the existing services were greatly cherished by the community as a whole, so any change to that service must be evidence based. He believed that there were a number of gaps in providing such evidence – namely:

- There needed to be a robust scoping exercise on how the closure of either maternity unit would affect the people of Greater Glasgow. He did not believe that there was sufficient evidence of this to satisfy all the communities of Greater Glasgow.

- Maternity services needed to be planned strategically on a West of Scotland basis. The Board needed, therefore, to initiate a planning mechanism for maternity services with neighbouring Boards which would greatly help address current medical staffing issues.

As such, he could not support recommendations 1 and 3 at this time and considered that maternity services be re-assessed on a West of Scotland basis.

Councillor Duncan and Mrs Nijjar stated that they supported the comments made by Mrs Kuenssberg and did not support closure of the QMH.

Mr Divers summed-up the discussion by stating that this was a difficult decision for the NHS Board, particularly with deeply held views on both sides and no clear clinical consensus. The Minister for Health and Community Care had asked the NHS Board to address the regional issues with Argyll and Clyde and Lanarkshire NHS Boards and this had been done. It was important to reach a decision now and work together with clinicians to deliver in the future the best and safest service for mothers and babies.

Sir John intimated that the ten recommendations were inter-linked and, therefore, he was seeking a vote on the acceptance or otherwise of the recommendations as a single package. The outcome would then be submitted to the Minister for Health and Community Care for consideration.

Twenty-two Members indicated their support for the full set of recommendations; five Members had already indicated their dissent from the closure of the Queen Mother's Hospital. Mrs Kuenssberg asked that her support for many of the other recommendations be recorded.

The Chairman thanked Members for a full and thorough discussion and the officers for the detailed papers on the outcome of the consultation on Modernising Maternity Services.

ACTION BY

DECIDED:

1.	That delivery services be located in the new facilities at the Princess Royal Maternity Hospital and high quality provision at the Southern General Hospital – the Queen Mother's Hospital be closed as soon as physical capacity was available and the necessary planning could ensure a safe transition for all the services it provided. This was likely to be around 12 to 14 months from a Ministerial decision.	**Chief Executive/ Director of Planning and Community Care**
2.	That in the context of the abolition of Trusts, the move to single system working and the need to look at appropriate organisational arrangements across NHS Greater Glasgow during spring and summer of 2004, the Corporate Management Team develop an appraisal of a single structure to manage maternity and paediatric services across Glasgow.	**Chief Executive/ Director of Planning and Community Care**
3.	That the report of the Maternity Planning Group form the basis of a change implementation plan to ensure that the quality of specialist paediatric services was not compromised.	**Medical Director**
4.	That community services be strengthened and extended by the provision of a maternity centre in West Glasgow providing an extended range of services, redeployment of midwives into community services and the implementation of public health midwifery, as proposed by the Maternity Services Liaison Committee.	**Director of Planning and Community Care**
5.	That both delivery units provide midwifery delivery beds aimed at low risk women.	**Chief Executives**
6.	That the Maternity Services Liaison Committee be asked to develop proposals to enable women to have the choice of direct access to midwives.	
7.	That fetal medical services be consolidated into a single major fetal-maternal centre at the Princess Royal Maternity Hospital, with a strong clinical network to paediatric and genetic specialists at Royal Hospital for Sick Children, providing services to the West of Scotland and a national interventional service.	**Director of Planning and Community Care**
8.	That the proposed pattern of community services would minimise access and transport issues but the Board should build on the programme of work established for the Acute Services Strategy implementation to address transport issues identified by communities during this consultation.	**Director of Planning and Community Care**
9.	That the decision on maternity services was taken within the new context where there was now strong clinical support for the co-location of adult, paediatric and maternity services. A process be put in place to bring proposals for the longer term disposition of specialist children's services to formal public consultation by the end of 2004. The Board should be quite explicit that it was making that commitment to bring forward those proposals based on the responses received from clinical staff to the consultation on maternity services.	**Chief Executive/ Director of Planning and Community Care**
10.	Confirm the commitment that any redeployment of staff required as a result of this decision should ensure the retention of skilled clinicians and the best use of their skills.	

The meeting ended at 2.20 pm

GGNHSB(M)04/5
Minutes: 57 - 69

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 18 May 2004 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Bannon MBE
Mr J Best
Dr H Burns
Mr R Calderwood
Mr R Cleland
Councillor J Coleman
Councillor D Collins (to Minute 65)
Dr B Cowan
Ms R Crocket
Mr T Davison
Mrs R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie
Dr R Groden
Mr P Hamilton
Councillor J Handibode (to Minute 66)
Mrs W Hull
Mrs S Kuenssberg CBE
Mr G McLaughlin
Mrs J S Murray
Mrs R K Nijjar
Mr I Reid
Mr A O Robertson OBE
Professor S Smith
Mrs A Stewart MBE

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

Ms E Borland	..	Acting Director of Health Promotion
Mr J Cameron	..	Director of Human Resources, South Division (for Minute 67)
Mr J C Hamilton	..	Head of Board Administration
Mr D McCallum	..	Development Manager, North Division (for Minute 66)
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr B Steven	..	Director of Finance, North Division (for Minute 66)
Mrs L Trendell	..	Senior Solicitor, Central Legal Office (for Minute 66)

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Mrs G Leslie	..	Chair, Area Optometric Committee
Mr H Smith	..	Chair, Area Allied Health Professionals Committee

ACTION BY

57. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Miss A Paul, Mrs E Smith, Cllr. A White, Mr J Cassidy (Chair, Area Nursing and Midwifery Committee), Mr C Fergusson (Chair, Area Pharmaceutical Committee) and Dr B West (Chair, Area Medical Committee).

The Chairman welcomed Dr Richard Groden, the new Chair of the LHCC Professional Committee, who was attending his first meeting of the NHS Board.

ACTION BY

58. CHAIRMAN'S REPORT

The Chairman invited Dr Harry Burns, Director of Public Health to update Members on the tragic incident at Maryhill on 11 May, 2004 and to comment specifically on the role of the NHS and its staff.

Dr Burns advised that 9 people had died and just over 40 had been admitted to hospital.

At just about 12.30 p.m. on Tuesday, 11 May, 2004 he had received a telephone call advising that, following an explosion in Maryhill, the Chief Constable had enacted the Major Incident Plan. 2 site medical teams were immediately dispatched to the incident.

As the emergency services carried out their tasks it had been necessary to consider the safety of those involved at the site in relation to the possibility of toxic fumes from the Plastics Factory. The Environmental Protection Agency and the City Council's Scientific Services Department were able to give reassurances from monitoring the atmosphere that no specific hazard of this nature had been detected.

Dr Burns praised the efforts of all the NHS staff from NHS Greater Glasgow and neighbouring NHS Boards; the emergency services and, in particular, the Fire Brigade. Their efforts had been outstanding in attempting to minimise the loss of life and injury. The Major Incident Plan had worked exceptionally well and this was as a result of the regular rehearsals undertaken of the Plan, led by the NHS Board's Emergency Planning Officer, Alan Dorn.

The A&E Departments had coped well with the additional numbers of casualties and intensive care beds were available within the city throughout the incident.

There would be a review of the NHS response to the incident to learn any lessons for the future and this would be followed by a major review by all the emergency services involved in the Major Incident Plan.

The Chairman wished recorded the NHS Board's heartfelt condolences and sympathies to the families who had lost loved ones in the incident. He had written to all NHS staff who had been involved, thanking them for their outstanding efforts in responding to this dreadful incident and asked the Chief Executive to write to the other emergency services to formally thank them for the role they played in co-ordinating and collaborating in responding to the explosion at the Plastics Factory. **Chief Executive**

59. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following issues:

a) The latest Joint Liaison meeting on 21 April, 2004 with Argyll and Clyde NHS Board which covered a range of issues, including the forthcoming consultation by Argyll and Clyde NHS Board on its Clinical Strategy.

b) The tri-partite meeting that afternoon (18 May, 2004) with Argyll and Clyde NHS Board and West Dunbartonshire Council on the health care needs of that area.

c) That he had forwarded to the Minister for Health and Community Care, a week after the April NHS Board meeting, the outcome of the consultation on Maternity Services and the NHS Board's recommendations. The covering letter to the Minister had been copied to NHS Board Members for information and the submission had included the supporting documentation which Members had previously received.

ACTION BY

60. MINUTES

Cllr. Handibode stated that, again, he had received a number of "To Follow" papers on the Monday before the NHS Board meeting, the papers having been delivered to the Council's offices on the Friday evening. He found this practice unacceptable as the papers required detailed reading and consideration. He asked that a deadline be set for papers being sent to the NHS Board – after which papers would be submitted to the next available NHS Board meeting.

Sir John indicated that he too had been disappointed to learn that a number of "To Follow" papers had to be sent to Members on Friday and he had discussed this with the Chief Executive.

Mr Divers accepted the point made by Cllr. Handibode and would be working over the summer with the Corporate Management Team towards a different way of working in order to achieve the reasonable request made by Cllr. Handibode about receiving NHS Board papers with adequate time to consider the issues raised.

On the motion of Mr R Cleland, seconded by Mr P Hamilton, the Minutes of the meeting of the NHS Board held on Tuesday, 20 April 2004 [GGNHSB(M)04/4] were approved as an accurate record and signed by the Chairman, subject to the following changes:-

i) Minute 50 – Modernising NHS Dental Services in Scotland: Scottish Executive Consultation Paper – Page 10 – 3rd paragraph – 4th line: delete "such".

ii) Minute 56 – Modernising Maternity Services: Outcome of Consultation – Page 18 – 9th paragraph – 5th line: delete "some key groups" and insert "neo-natal staff".

61. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was circulated and noted.

NOTED

62. EMERGING PRESSURES IN ACUTE SERVICES

A report of the Programme Director – Acute Services Implementation [Board Paper No. 04/29] was submitted addressing the significant challenges faced by the NHS Board in sustaining the present pattern of services for the timescales envisaged in the Acute Services Review.

This issue had been discussed at the NHS Board meeting in December 2003 and Dr Cowan explained the key drivers for change as:

- Outdated buildings – unsuitable and unfit for modern health care.
- In-patient sites which were unable to provide one-stop/rapid diagnosis and treatment models for large volumes of patients.
- Fragmentation of care as patients were required to move around sites and different buildings, leading to an inevitable loss of continuity and difficulties in transferring information.

- Unsuitable diagnostic and imaging facilities which restricted capacity, created bottlenecks and inevitable delays in treatment.

- Increasing sub-specialisation within medicine – a move towards larger teams to ensure all patients could get access to appropriate specialists.

- Glasgow's role in teaching and research and their link with the Universities was critical for the service to attract and retain high calibre staff.

- Too many in-patient sites requiring emergency on-call rotas on each site with pressures going on both Consultants and junior staff.

- Changes in doctors' training – would mean Consultants were being called in from home more often or opting to do resident on-call to provide support to junior staff.

- Restrictions on the hours doctors could work – New Deal for Junior Doctors; limited number of hours; European Working Time Directives; restricted availability of Consultants due to compensatory rest requirements.

- Policy imperatives outlined in the Scottish Health Plan and Cancer Plan which included waiting time guarantees; reductions in waiting times; improved access to rapid diagnosis and treatment; the provision of services designated around the needs of patients; and improved integration with primary and social care.

In addition, Dr Cowan highlighted the most significant problems and pressures being faced by the NHS Board – New Deal for Junior Doctors; Consultants Contract; SIMAP – time spent in work being counted as working hours including sleeping time; Modernising Medical Careers – changes to the training of Senior House Officers from August 2006; and the European Working Time Directives. In addition, since the report to the December Board, there also had been the worsening financial position for NHS Greater Glasgow and the need to reduce costs of Glasgow's hospital services without compromising effectiveness or the safety of patients.

The pressures on services were building up and bringing forward some of the agreed changes would have significant advantages and lead to better and safer services to patients. Currently there was not always adequate specialist out-of-hours cover available and this was not an acceptable level of service for patients.

It was reaffirmed that there was nothing in the proposals which was at odds with the decisions taken in agreeing the Acute Services Strategy in terms of the number and disposition of services.

Mr Calderwood advised that a pan-Glasgow Acute Services Review (ASR) Acceleration Group was set up and it had been developing a number of themes for discussion. Mr Calderwood reminded Members that the principles of the Acute Services Strategy had been to develop locally accessible out-patient and day surgery services from 5 sites and to consolidate in-patient services at Glasgow Royal Infirmary, Southern General and Gartnavel General with Accident & Emergency/Trauma being provided from Glasgow Royal Infirmary, the Southern General and Acute Emergency Receiving from Gartnavel General.

In turning to Section 3 of the paper, he highlighted a number of imperatives which had been identified by the ASR Acceleration Group:-

ACTION BY

1. Only an early reduction in the number of staffed emergency service sites would enable the NHS Board to address the pressures identified by Dr Cowan.

2. The Casualty service at Stobhill Hospital could not be sustained beyond August, 2005.

3. A consolidation in the number of smaller specialties was required sooner rather than later.

4. The limited availability of beds at Glasgow Royal Infirmary and the Southern General sites was a significant block to achieving early change.

He then described the detailed proposals for early change as follows:

- Aim to achieve single emergency and elective sites for each of the three sectors of the city – North and East, South and West meaning proposals would be developed to reorganise emergency and elective workload between – Royal Infirmary and Stobhill; Gartnavel and the Western; Victoria and the Southern.

- Consolidation of Orthopaedics from the present five sites to the two planned sites, with a re-profiling of emergency and elective activity to reflect the East and West split and distribution of clinical resources accordingly.

- Create capacity for emergency care at the Royal Infirmary and Southern General – this may include an early move of Cardiothoracic Surgery from the Royal Infirmary to the Golden Jubilee National Hospital (GJNH). This could be a first stage of the proposals to consolidate all West of Scotland Cardiothoracic surgery at GJNH.

- The Services, Beds and Capacity Sub-Group of the ASR Programme Board to finalise the disposition of smaller specialties should be re-framed to make recommendations on potential interim service moves as soon as possible.

- Work with senior clinical staff on how to put in place arrangements to avoid concerns over patterns of work, status, clinical leadership and management arrangements to avoid any obstacles to achieving the change necessary.

- Early consolidation would require the use of existing physical facilities and the restrictions on the short term availability of capital.

The objective would be to have achieved the changes outlined above by the end of 2007 which would be alongside the opening of the first phase of the new Beatson Oncology Centre and the new Ambulatory Care Hospital facilities at the Victoria Infirmary and Stobhill.

Mr Davison provided Members with a background to the Casualty service at Stobhill and the difficulties being experienced with achieving accreditation of this service for training purposes for junior doctors. The Casualty Department was staffed by five Senior House Officers (SHO), without on-site Accident and Emergency Consultant cover and therefore had inadequate clinical and training supervision. The accreditation bodies (the Royal College of Surgeons and the Royal College of General Practitioners) had previously indicated that they would withdraw recognition of the SHO posts for training purposes in February, 2004 and this would have led to a closure of the Casualty service at Stobhill.

ACTION BY

Clinicians and management of North Glasgow had worked hard to put in place an interim solution and the Accreditation Committee had confirmed that it would give accreditation to these posts until August, 2005 to enable the NHS Board to plan and manage the transfer of service. This interim solution would involve the rotation of SHOs throughout North Glasgow departments, including Stobhill; Accident and Emergency Consultants within North Glasgow providing sessional cover at Stobhill; improving middle grade support and physical and equipment improvements to the department. The Royal Colleges had indicated that the extended accreditation to August, 2005 was only on the basis that the NHS Board committed to work to the closure of the unit by August, 2005.

The Accident and Emergency Sub-Committee had previously offered advice that the Casualty model at Stobhill was not a safe and sustainable service to deal with emergency patients. Two potential options would be developed for discussion: the first would see Stobhill continuing to provide acute medicine and surgery cases referred by their GP – all other patients would attend Accident and Emergency departments. The second would consolidate all emergency activity for North and East at the Royal Infirmary and fully utilise Stobhill to provide elective services and rehabilitation for a larger catchment population than is presently the case. A Minor Injuries Unit would also be provided.

Mrs Dhir asked about the public engagement/consultation proposals. Mr Calderwood advised that any such proposals would be submitted to the NHS Board for approval prior to public engagement. They would clearly include the North and South Clinical Planning Forum, the Acute Strategy Monitoring Groups, Local Health Council and key stakeholders, including the public. It was reiterated that the Ministerial commitment to sustain services at Stobhill and the Victoria Infirmary for a 5-year period was based on the Monitoring Groups participating in discussions about any proposed changes to named services if this was required for reasons of clinical safety. The presentation by Dr Cowan had very clearly highlighted the clinical need and safety reasons for change and that current services were not sustainable and the changing pattern of these services required to be addressed.

Dr Burns advised that in terms of the preparedness for emergencies, the success in responding to major incidents was down to staff. It was essential therefore that staff had access to full and proper training in accredited facilities and this was also hugely important in terms of recruiting high calibre staff to the NHS in Greater Glasgow. For the longer term benefit of patients, there was no alternative but to recognise the need for the significant changes required in our services in order to deliver a modern, safe and sustainable service to patients delivered by a well-trained and motivated specialist staff.

Mr Robertson supported the direction and proposals contained within the paper and was pleased to see they were consistent with the Acute Services Strategy. Mr Cleland re-emphasised that, in consulting on proposals for change, the NHS Board had to take account of the Accreditation Committee's decision that Stobhill Casualty would not be accredited for training purposes from August 2005. What would be prepared for discussion would be the shape and pattern of services that would be required recognising the closure of the Casualty Unit.

ACTION BY

Mr Hamilton raised the Ministerial commitment for the NHS Board to review Accident and Emergency services two years after the decision to move to two A&E/Trauma units. Mr Divers advised that a review of the robustness and appropriateness of the decisions relating to Accident and Emergency was required two years after the Ministerial commitment to undertake such a review, i.e. Autumn, 2004. This would test whether the NHS Board decision to move to two A&E/Trauma Units with Acute Emergency Receiving at Gartnavel General Hospital was still appropriate. There would be engagement with the Local Health Council and other key stakeholders to test that decision and a report back to the NHS Board on the outcome.

Mr McLaughlin enquired about the additional resources necessary to support the acute services implementation and Mr Calderwood advised that there would be shared resources across the Divisions and NHS Board and the continuation of the arrangements with the external advisers. A Project Team of 6/8 staff would be working on the implementation phase.

Sir John, in concluding the discussion, intimated that there would be regular reports to NHS Board Members either at the NHS Board, Performance Review Group or Seminars and these would assist in shaping the outcome of the proposals which it was planned to submit to the NHS Board in October for approval. Staff had been making huge efforts to sustain the current level of services and the NHS Board was grateful for their efforts during this difficult time.

DECIDED:

1. That the proposed approach to the acceleration of the Acute Services Review, with detailed proposals to be brought forward to future NHS Board meetings for approval prior to public engagement, be approved. **Programme Director – Acute**

2. That the requirement to close the Casualty service at Stobhill by August, 2005 be accepted.

3. That the commitment to the major capital developments at the Southern General and Glasgow Royal Infirmary, approved as part of the Acute Services Review, be confirmed. **Programme Director - Acute**

63. BALANCING THE FINANCIAL POSITION IN 2004/05

A report of the Chief Executive [Board Paper No. 04/30] was submitted and picked up on the further work of developing and implementing the Corporate Recovery Plan and gave a summary update on each of the key clusters of work within it. It sought Board approval to a range of actions within the Plan; identified how the plan was to be developed through further work with staff, partners and other interests and highlighted specifically where formal consultation was required on proposed changes to service delivery.

Mr Divers took Members through the main elements of the paper:-

1. How was balancing the financial position being taken forward?

   There were two main strands to this work: firstly, a continuation of the tight budgetary control measures which were adopted in response to the financial, pressures which developed during 2003/04. It seemed likely that the financial outturn for 2003/04 would have come within the lower estimates submitted to the NHS Board and the Performance Review Group during the second half of the financial year and this was helped by the release of a non-recurrent allocation by the Ministers to NHS Boards at the latter part of the year. It was vital therefore that across NHS Greater Glasgow the budgetary controls on manpower and on non-pay expenditure continued to be applied with the sensitive rigour which was applied last year. Secondly, the NHS Board had been developing a Corporate Recovery Plan which was aimed at reducing expenditure across the range of the Board responsibilities, through planned changes to enable the NHS Board to return to financial balance within a maximum of two years.

2. Developing the next steps in the Corporate Recovery Plan

   The Corporate Management Team tested the reliance and durability of the Plan in a half-day Workshop which was facilitated by the Board's external auditors, PricewaterhouseCoopers. Further sessions would be held shortly with other key stakeholders such as the Partnership Forum and groups of clinical leaders.

   To assist in monitoring the project, there would be a common set of project documentation which would be prepared identifying the Project Leader, key objectives of the project, milestones and timescales for delivery and this would be managed by a Project Manager – Douglas Griffin, Director of Finance, Primary Care Division.

   He would co-ordinate the work of the individual projects and support the Chief Executive and Corporate Management Team in executing the Plan. Monitoring implementation of the Plan would be reported routinely to the Performance Review Group and, through it, periodically to the NHS Board.

3. Taking action in moving the Plan forward

   There were several clusters of actions which comprised the current Plan and these saw pan-Glasgow reviews in Finance and Supplies, Human Resources, Pharmacy, Laboratories, Catering, Medical Illustration and Management Costs.

   Following the earlier public consultation exercises, the plans to implement in-patient Dermatology onto a single site at the Southern General and the in-patient Gynaecology for North-East Glasgow within Glasgow Royal Infirmary would now proceed.

   There would also be consideration to closing the 15 in-patient beds at the Homoeopathic Hospital and continuing the service through day and out-patient services. This proposal would be the subject of a consultation exercise carried out during the next two months. There would also be a review carried out of stand-alone rehabilitation sites and if integration with a major adult site was feasible and desirable those proposals would then become subject of formal consultation alongside proposals for the future use of any affected sites

The benchmarking of the performance of adult acute hospitals against an extensive range of comparative hospitals across the UK suggested there was significant scope for achieving greater efficiency in the use of beds in several acute specialties. This would be taken forward in discussions with lead clinicians.

Yorkhill Division had been analysing the potential to reduce beds in areas where occupancy levels were relatively low.

Planning Groups responsible for reviews of elderly continuing care and mental health beds and day hospitals were to complete their reviews shortly.

4. Engagement with key interests in taking forward the Plan

Two initial sessions had been held with staff partners (one with full-time officials and the other with the staffside members of the Area Partnership forum). Monthly meetings with these two groups together had been set for the rest of the year and there would be ongoing dialogue with each Local Partnership Forum. An initial meeting had taken place with members and officers of the Local Health Council, with a further meeting proposed. A meeting with MSPs had been offered. Discussion on the implications of the Plan were being taken forward with Local Authority partners, through the Local Health Plan Steering Group and the local Council-based planning structures.

Cllr. Handibode welcomed the very detailed report and asked about how confident the officers were in achieving the savings target and the potential additional income of £10 million due from West of Scotland Health Boards. Mr Divers advised that it would be important to demonstrate to the Performance Review Group whether the savings target was deliverable and if any elements were not, what plans would be put in place to fill that gap. In relation to the cross-subsidisation, he indicated that Catriona Renfrew and Wendy Hull had prepared a paper for the West of Scotland Health Boards identifying the cost that NHS Greater Glasgow believed should be paid for West of Scotland patients accessing national and specialist services within NHS Greater Glasgow. This dialogue was also being pursued with the Scottish Executive Health Department and, whilst it was important to include within the plan a target to be achieved, if the sum was to be made good it was likely that this would be over a timeframe that would be subject to debate and negotiation. Sir John emphasised that regional planning and cross-subsidisation issues were now being discussed at the NHS Board Chairmen's meeting and also with Scottish Executive Health Department officials.

Mr Robertson advised that at the next Performance Review Group it would be reviewing the strands identified in the Chief Executive's paper and also the progress in developing a single Corporate Recovery Plan. Whilst pleased to see that the financial outturn for 2003/04 may come within the lower estimates submitted to the NHS Board and Performance Review Group, he was particularly concerned that the recurring element of the Board's financial positions still required to be addressed urgently and all steps identified in the Chief Executive's paper were a necessary part of that process.

ACTION BY

DECIDED:

1. That the progress report on balancing the financial position in 2004/05 be received.

2. That the steps proposed in further developing and implementing sections of the Plan, as described in the paper, be approved. **Chief Executives**

3. That the significant changes in services proposed within the paper should be the subject of formal consultation – in particular, the proposal to close the in-patient beds at the Homoeopathic Hospital. **Chief Executives**

4. That the Corporate Management Team and Performance Review Group review urgently investment proposals which currently sat within the financial plan for 2005/06. **Chief Executives/ Director of Finance**

5. That the arrangements for the submission of regular reports to the Performance Review Group and the NHS Board itself, be approved. **Chief Executive**

64. PAN-GLASGOW DECONTAMINATION SERVICE

A report of the Chief Executive, Yorkhill Division [Board Paper No. 04/31] was submitted seeking NHS Board approval to the development of a fully compliant decontamination service centralised within a single industrial unit at Cowlairs under a lease agreement for an initial period of 23 years.

Mr Best took Members through each section of the paper, reminding Members that the Outline Business Case had been approved by the Board at its November, 2003 meeting and also by the Scottish Executive's Capital Investment Group.

None of the six Decontamination Units (TSSU) serving Glasgow's acute Divisions were capable of upgrade to comply with the new national and technical standards as recommended by the Glennie Group Report (2001) and Medicines and Healthcare Products Regulatory Agency (MHRA). The project was a new development for the NHS and there had been significant input from advisers. Both Scottish Healthcare Supplies and the Scottish Centre for Infection and Environmental Health had been involved in regard to process flows, design layout of the new unit and equipment requirements.

Mr Best detailed the timetable and key milestones and anticipated that, if approved, the building conversion works could be completed with equipment installed and commissioned between February and March, 2005. The transfer of the existing decontamination services into the new Cowlairs unit would then commence in April/May, 2005 with completion by December, 2006.

It was proposed that the Board lease the premises for a minimum of 23 years at an annual rental of £108,000. Indicative cost of conversion of the premises was £8.9 million – building works £6.2 million and equipment £2.7 million. The total revenue impact of the preferred option was £5.4 million, representing an increase of £1.9 million to the existing recurring revenue costs and, together with a further £0.5 million cost relating to unfunded costs, this would bring the additional sum required to fund the project to £2.4 million. These figures did not include the transitional cost, in particular the one-off capital required to purchase theatre instrumentation to support an off-site service (possibly £3 million), together with additional transitional costs mainly relating to training. This would result in a £4.393 million additional costs over the four financial years of the implementation of the project.

ACTION BY

Mr Best explained the contingency plans and developments since the Outline Business Case had been approved by the NHS Board.

Mr Cleland enquired about the position with regard to staffing and Mr Best advised that a human resources group, including staffside representation, was taking forward the migration of staff and it was likely that providing a centralised service would lead to an increased need for staff.

Mrs Stewart enquired about the maintenance arrangements and contingency plans and Mr Best confirmed the issues highlighted in the paper around these arrangements.

In responding to Dr Groden's comment about primary care contractors and dental services, he advised that general dental practitioners made their own arrangements for sterilisation of their equipment and the Glasgow Dental Hospital and School operated a separate local scheme. Dr Angell advised Members of the requirements for increased instrumentation of general dental practitioners if they were required to move away from their existing arrangements.

Mr Best agreed to keep Members advised of the progress with regard to the creation of a centralised decontamination service for NHS Greater Glasgow.

DECIDED:

1. That the requirements to comply in full with the new national quality and technical standards for the provision of Decontamination Services within agreed timescales be noted.

2. That the proposals to achieve full compliance with the development of a pan-Glasgow Decontamination Service centralised within an NHS managed industrial unit, located at Cowlairs in the North-East of the city, be approved. **Chief Executive, Yorkhill Division**

3. That the signing of the lease for the industrial unit at Cowlairs for an initial period of 23 years, be approved. **Chief Executive, Yorkhill Division**

65. 2004/05 AND BEYOND – CAPITAL PLAN ALLOCATION

A report of the Director of Finance [Board Paper No. 04/32] was submitted to the NHS Board seeking approval to the Capital Allocations for 2004/05.

Mrs Hull introduced her paper by indicating that capital allocations had been devolved to NHS Boards in 2002/03 and that local approval processes and procedures had been agreed by the Board and the Audit Committee in October, 2002. The proposals set out in this report had been prepared in line with that agreed policy. Priority had been given to schemes that:-

1. allowed the completion of legally committed schemes;

2. enabled the acute services reconfiguration;

3. ensured ongoing commitments to previously agreed schemes and requirements for regular investment in medical equipment maintenance, IT, health and safety and decontamination.

ACTION BY

In response to a question from Mr Robertson, Mrs Hull advised that the Corporate Management Team would be tasked with approving the schemes contained within the total formula allocation of £12 million.

Mrs Dhir and Cllr. Handibode enquired about Table 1 and the sale of properties. Sir John asked that Members receive a briefing paper on the surplus land and buildings within NHS Greater Glasgow and the up-to-date position with regard to disposal arrangements. Mr Davison advised that the site of the former Belvidere Hospital had indeed been on the market and had been withdrawn for a period of time during its inclusion within the options for the proposed Secure Unit. Discussions had been held with the City Council about whether a joint venture was possible, however, the site had now been re-marketed and the extent of interest in the site was now being appraised.

DECIDED:

1. That the capital allocations proposed for 2004/05 totalling £67.177 million be approved. **Director of Finance**

2. That approval for 2005/06 totalling £29.43 million (so that the allocation was balanced over the two financial years) be given outline approval. **Director of Finance**

3. That the priorities used to determine the schemes proposed for inclusion in the capital programme be confirmed. **Director of Finance**

4. That the inclusion of receipts from anticipated land sales in future capital funding available be agreed and a briefing paper on land disposals be prepared for NHS Board Members. **Director of Finance**

66. GLASGOW ROYAL INFIRMARY – CONTRACT FOR CAR PARK MANAGEMENT SCHEME

A report of the Chief Executive, North Division [Board Paper No. 04/33] was submitted seeking the NHS Board's approval to entering into the contract for the car park management scheme at Glasgow Royal Infirmary.

Mr Davison introduced Mr Brian Steven, Director of Finance, North Division; Mr Duncan McCallum, Development Manager, North Division; and Mrs Lynne Trendell, Senior Solicitor, Central Legal Office, who were attending and would answer Members' questions.

The provision of a car park at Glasgow Royal Infirmary remained an obligation under the original planning consent for the recently built Princess Royal Maternity Hospital and a new A&E Department. The Full Business Case had been approved by the NHS Board at its July meeting and by the Scottish Executive Capital Investment Group in August, 2003. There had been some delay in completing the contract negotiations with the preferred bidder, Impregilo. These delays had been around the road construction consent for improvements to the main access from Alexandra Parade, a land title issue and a congestion charges element of the contract.

As a consequence of these delays, contract close had not been reached prior to the dissolution of the North Glasgow Trust and a Minute of Authorisation was now required as the NHS Board would now be entering this contract with Impregilo.

ACTION BY

Car parking space numbers with the scheme had been finalised at 1,408 although during the construction phase car parking at the Royal would reduce from 440 spaces to 294.

Due to excess demand, the price of steel had increased by close to 20% since the Final Business Case (FBC) stage and it was expected again to rise at the end of May, 2004 and therefore time was of the essence in completing the Contract.

DECIDED:

1. That Members were re-appraised by the information provided and approval given to the Glasgow Royal Infirmary Multi-Storey Car Park Full Business Case in July 2003.

2. That the relevant changes which had taken place between the FBC approval in July 2003 and subsequent contract finalisation, be noted.

3. That the current situation regarding the price of steel and the potential for this to terminate the contract be recognised.

4. That the NHS Board Chief Executive and other duly authorised Directors be authorised to sign the PFI Contract for the provision of a multi-storey car park at Glasgow Royal Infirmary. **Chief Executive/ Director of Finance**

5. That the NHS Board Chairman be authorised to sign the Minute of Agreement to allow the Central Legal Office to complete the legal formalities. **Chairman**

67. NHS GREATER GLASGOW DRAFT CAR PARKING POLICY

A report of the Chief Executive, Yorkhill Division [Board Paper No. 04/34] was submitted enclosing a draft Car Parking Policy for formal discussion and engagement with NHS patients, public and staff.

Mr Best introduced the paper in his capacity as Chairman of the Acute Services Strategy Transport and Access Group and introduced Mr Jim Cameron, Director of Human Resources, South Division, to take Members through the principles contained within the paper.

Mr Cameron advised that the NHS Board had been facing increased pressure and difficulties in managing the rising number of patients, visitors and staff seeking limited car park spaces on NHS sites and this had led to a high degree of congestion and environmental problems for the local surrounding population. Scottish Executive guidance required the development and implementation of green travel plans when new developments were due to take place and the granting of planning permission could be dependent on agreeing a satisfactory Green Travel Plan.

The draft Policy had been developed by a Working Group including staffside representatives and remitted to develop arrangements for a fair and equitable access for patients, visitors and staff to existing car park spaces. The draft Policy had been produced as a key component of a Green Transport Strategy which was currently being developed. It was also integral to the implementation of the Acute Services Strategy.

ACTION BY

The draft Policy was a framework document setting out the principles which would underpin any implementation plan for car parking charges and the NHS Board's approval was being sought for the policy framework to be issued for comment and discussion with patients, visitors and staff with the intention of implementing new arrangements from 1 April, 2005.

Mr Calderwood sought clarification to the hospital sites listed in paragraph 1.4 of the draft Policy. Mr Cameron advised that this was an indicative list and did not include Primary Care/Community Health Clinics. These two points would be made explicit within the consultation document.

Mr Goudie raised an issue in relation to paragraph 2.1 and the ability of staff to be able to pay car parking charges. He would prefer to indicate that the Policy would reflect staff's ability to pay as opposed to may reflect. This would be altered and would obviously form part of the consultation process.

In response to a number of questions raised by Members, Mr Cameron advised of the national guidance being considered by the Transport and Access Group as it considered transport access issues to health care facilities; the draft Policy would be more explicit around green transport alternatives and he explained the shuttle-bus arrangements from key public transport hubs.

Mrs Stewart asked whether it would be possible to be more explicit about the criteria whereby free parking permits could be made available to patients under exceptional circumstances. Dr Groden asked if consideration could be given to the charging policy when situations may arise where patients had been delayed within out-patient clinics.

Sir John asked that if Members had other points they wished to raise with Mr Cameron they should do so direct and this would then allow the draft Car Parking Policy to be finalised and submitted for discussion and engagement with patients, public and staff.

DECIDED:

1. That the draft Car Parking Policy framework and principles which underpinned it , subject to the amendments above, be approved. — **Director of Human Resources, South Division**

2. That the amended draft Policy framework be issued for formal discussion and engagement with patients, public and staff be approved. — ***Director of Human Resources, South Division***

3. That, subject to the feedback from the engagement process, the NHS Board receive a further paper in 2004/05 seeking formal approval and implementation of the Car Parking Policy. — ***Director of Human Resources, South Division***

68. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No. 04/35] asked Members to note the progress on meeting waiting time targets.

ACTION BY

Ms Renfrew highlighted the change in reporting from specifically monitoring patients waiting under nine months to patients waiting under six months for in-patient and day case treatment. Reporting still differentiated NHS Greater Glasgow patients without availability status codes and those with. This report would be further developed in the coming months to include out-patient targets and performance against these targets. She highlighted that the variance of 55% for Yorkhill was, in fact, only an additional 43 patients for March to April, 2004.

The initial investments to deliver the targets set for December, 2005 had now been implemented and adverts had been placed for the appropriate staff.

Mr McLaughlin enquired as to whether consideration had been given to setting an initial 31 December, 2004 target. Mr Divers advised that as the monthly monitoring reports indicated, reduction in patients for treatments was not a straight line reduction or trend. The waiting time target of six months for in-patient and day case cases by December, 2005 was a huge challenge for NHS Greater Glasgow and involved many thousands extra treatments. The NHS Board, through its initial investment plans, had begun to gear itself for reaching this target and had thus far resisted attempts to determine any interim target by the end of this calendar year. Mr Davison added that with the new out-patient waiting time target it was necessary to fully understand and predict the impact on in-patient waiting times of shortening the out-patient waiting time period and this was still currently being worked through.

Sir John indicated that the strategic financial and clinical element of meeting the out-patient and in-patient waiting time target would be a useful topic for a future NHS Board Seminar.

NOTED

69. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES

The Minutes of the Health and Clinical Governance Committee held on 27 April 2004 [HCGC(M)04/2 were noted.

NOTED

The meeting ended at 11.50 a.m.

EMBARGOED UNTIL MEETING

NHS Greater Glasgow

Greater Glasgow NHS Board

Board Meeting

Tuesday 18th May 2004 **Board Paper No. 2004/29**

Programme Director Acute Services Implementation

Emerging Pressures in Acute Services

Recommendation:

- **The Board:**
  - **endorse the proposed approach to the acceleration of the Acute Services Review with detailed proposals to be brought to a future Board meeting for approval prior to public engagement**
  - **note the requirement to close the casualty service at Stobhill by August 2005;**
  - **confirm its commitment to the major capital developments at the SGH and GRI approved as part of the ASR.**

A. BACKGROUND AND PURPOSE

1.1 The Board considered a paper "Emerging Pressures in Acute Services" 2003/73(a) at its December 2003 meeting. That paper set out the significant challenges to sustain our present pattern of services for the timescales envisaged in the Acute Services Review.

1.2 The purpose of this paper is to describe our progress in addressing those issues. It is important to restate the context in which the remainder of this paper has been put forward.

1.3 General acute services in Greater Glasgow are currently provided as follows:

- six sites with general acute services at Gartnavel, the Western Infirmary, Stobhill, Glasgow Royal Infirmary, Southern General and Victoria;
- four Accident and Emergency and one Casualty departments.

1.4 In March 2000 we set out proposals for significant service change. The key drivers for these proposals were:

- **Outdated buildings,** unsuitable and unfit for modern healthcare - 21st century healthcare in19th century buildings.

- **Inpatient sites** which are unable to provide the one stop / rapid diagnosis and treatment models for the large volumes of patients treated in Glasgow hospitals.
- **Fragmentation of care** as patients are required to move around sites and different buildings, an inevitable loss of continuity and difficulties in transferring information e.g. laboratory results and x-rays between sites.
- **Unsuitable diagnostic and imaging facilities** which restrict capacity, create bottlenecks and inevitable delays in treatment.
- **Increasing sub-specialisation in medicine** – a move towards larger teams to ensure all patients can get access to the appropriate specialist .
- **Glasgow's role in teaching and research** and the links with the Universities, is critical for the service to attract and retain high calibre staff - critical in services where there are national shortages e.g. cancer, cardiac surgery, diagnostic imaging and pathology amongst others.
- **Too many inpatient sites requiring emergency on call rotas** on each site - with pressures growing on both consultants and junior staff.
- **Changes in doctors' training** – means consultants are being called in from home more often, or opting to do *resident on–call to* provide support to junior staff.
- **Restrictions on the hours doctors can work**: New Deal for Junior Doctors limits number of hours; European Working Time Directive restricts availability of consultants due to compensatory rest requirements.
- **The policy imperatives** outlined in the policy papers The Scottish Health Plan and The Cancer Plan which include waiting list guarantees, reductions in waiting times, improved access to rapid diagnosis and treatment, the provision of services designed around the needs of patients and improved integration with primary and social care.

1.5 In August 2002, after a prolonged process of planning, clinical and public debate the Minister approved proposals to reshape acute services, with a major programme of capital investment in the period to 2012. The pattern of acute services at that point would be:

- two major in-patient units with Accident and Emergency and Trauma services, at Glasgow Royal Infirmary and the Southern General;
- an in-patient hospital at Gartnavel providing local medical and surgical emergency services for General Practitioners colocated with the new West of Scotland Cancer Centre;
- ambulatory care hospitals at Stobhill and the Victoria, including minor injury services.

1.6 The most significant problems and pressures which are currently facing us are:

- <u>New Deal for Junior Doctors</u>

  This agreement requires junior doctors to work no more than 56 hours in a full shift pattern or 64 hours on a partial shift pattern. We have not been able to achieve these targets on all rotas and a number of rotas which do comply do so on a fragile basis ie small additional demands will make them non compliant. Our most acute frontline rotas such as Accident and Emergency, Anaesthesia and Surgery slip into non-compliance if the intensity of work increases and doctors are unable to get the required amount of rest. The new deal also has a significant impact on consultants. Junior staff are available for less hours and have less experience. That means consultants are much busier

when on call and, therefore, the frequency of on call is becoming a major issue.

- Consultant Contract

  The consultant contract, currently being finalised for implementation, will have a number of effects. It will require us to recognise and pay for hours and activities above core sessions and, therefore, makes intensity and frequency of on call activity of greater significance. In December the impact of the contract was not yet clear. We now know that there are substantial numbers of Glasgow doctors with unsustainable patterns of working which are also not affordable.

- SIMAP

  In August 2004, all time spent in work will be counted as working hours - requiring a maximum of 56 hours for all junior doctors. Currently many junior doctors are on partial shifts where they can work legally up to 64 hours if they are able to get guaranteed sleep during their time in hospital. This type of rota will have to disappear and will therefore reduce dramatically the number of hours juniors are available for work.

- Modernising Medical Careers

  This UK wide policy radically changes the training of Senior House Officers (SHOs) from August 2006. It puts a much heavier emphasis on training rather than service input. Its effect will be to put major pressure on hours of work for SHO rotas in all specialties and reduce the number of SHOs available to be on-call, especially in Accident and Emergency and Anaesthesia.

- European Working Times Directive

  The European Working Times Directive requires us to achieve a maximum of 58 hours for all junior doctors by 2004, reducing to 48 hours by 2009. The New Deal allows junior doctors to work up to 56 hours. Consultant medical staff currently work an average of 57 hours and should already be working 48 hours at present.

- Capacity

  The new waiting times target of 6 months require us to step up efficiency, higher levels of productivity could be achieved by working on fewer sites.

These points put particular pressure on the following services:

Stobhill	:	Casualty, Anaesthesia and General Surgery.
South Glasgow	:	Surgery and Trauma, Accident and Emergency, Anaesthesia and Intensive Care.

1.7 A further issue since our December report has been the worsening financial position. We need to reduce the costs of Glasgow's hospital services without compromising effectiveness or the safety of patients. That becomes a further driver for early change.

1.8 It is important to restate two key points:

- there is nothing in our proposed way forward which is at odds with the decisions we took at the end of the Acute Services Review in terms of the number and disposition of services;
- while any accelerated proposals cannot be supported by upfront, significant, capital investment and will therefore require the reuse of existing facilities they do not undermine or dilute our absolute commitment to the full, agreed programme of capital investment to renew Glasgow's hospital facilities.

1.9 In terms of progress since the 2002 decision, there are a number of important points. We have delivered consolidation of gynaecology, ENT and orthopaedic services. the procurement of the ACADs is on track to see them open in 2007. A proposal which emerged from a clinical consensus about the early consolidation of cardiac surgery for the West of Scotland, at the Golden Jubilee National Hospital, is being developed for consultation.

1.10 Finally, the Ministerial Monitoring groups for Stobhill and the Victoria have been meeting regularly and we would intend to fully engage them in the programme of work outlined in the rest of this paper.

B. STOBHILL CASUALTY

2.1 We have previously highlighted that the most immediate issue of sustainability relates to Stobhill casualty. The December Board paper flagged this as a service where the pressures are particularly acute. The root of the problem is that we have a department staffed by five SHOs, without onsite Accident and Emergency consultant cover and therefore with inadequate clinical and training supervision. The accreditation bodies had previously indicated that they would withdraw recognition of the SHO posts for training purposes in August 2004. This would have meant that the service would have had to close, a that point. The clinicians and management team in North Glasgow have worked hard to put in place an interim solution, which we have just had confirmation will enable the Accreditation Committee to accredit the SHO posts until August 2005 to enable us to plan and manage the transfer of the service.

2.2 The interim solution has a number of components:

- rotation of SHOs through North Glasgow departments including Stobhill;
- Accident and Emergency consultants within North Glasgow providing sessional cover at Stobhill;
- improving middle grade support;
- physical and equipment improvements to the department.

These solutions, which have impressed the Royal Colleges significantly enough to provide extended accreditation are viable only on the basis we commit to work towards a 2005 closure

2.3 It is also important to note the Accident and Emergency Sub Committee have offered advice, on a number of occasions, that the casualty model at Stobhill is not a safe and sustainable service to deal with emergency patients.

2.4 In the light of the issue of accreditation, clinical safety, our commitment to early rationalisation of clinical services and our financial position it is imperative that we begin to plan now for the closure of the Stobhill casualty at that point. We have identified two potential options that we propose to develop for consultation.

2.5 The first would see Stobhill continue to provide acute medicine and surgery at Stobhill for cases referred by their GP, with a minor injuries unit - all other patients would attend Accident and Emergency departments.

The second would consolidate all emergency activity for the North and East at the GRI but fully utilise Stobhill to provide elective services and rehabilitation, for a larger catchment population than is presently the case. A minor injuries unit would also be provided.

It is important to highlight that this second option would not meet the minimum commitment to sustain named services at Stobhill until 2007, but we do not believe it should not be developed for consideration by the Board as it may offer a safer and more effective service than the first alternative.

C. ACCELERATION, KEY ISSUES AND PROPOSALS

3.1 Following the December discussion we established a pan Glasgow ASR Acceleration Group led by the Programme Director: Acute Services Implementation. The ASR Acceleration Group has been testing ideas about how the ASR can be accelerated. We have already identified a number of imperatives:

- only an early reduction in the number of emergency service sites we are trying to staff will enable us to address the pressures which section 1 of this paper described;
- it is clear, as outlined in the previous section, that the casualty service at Stobhill cannot be sustained beyond August 2005;
- we need to achieve the consolidation of a number of smaller specialties sooner rather than later because of the pressures outlined in the opening section of this paper;
- the limited availability of beds on the GRI and SGH sites is a significant block to achieving early change.

3.2 Our conclusion is that our detailed proposals for early change should be developed with the following framework:

- we should aim to achieve single emergency and elective sites for each of the three sectors of the city, North and East, South and West and North West; This means that we will develop proposals to reorganise emergency and elective workload between:
  - the GRI and Stobhill;
  - Gartnavel and the Western;
  - Victoria and the Southern;

- consolidation of orthopaedics from the present five sites to the two planned sites, with a reprofiling of emergency and elective activity to reflect an East West split and the distribution of clinical resources accordingly;
- we should endeavour to ensure that acceleration proposals do not require significant capital investment in facilities which are not part of the final shape of acute services and where interim service moves are required these should be made with absolute clarity on what the final disposition of the service will be;
- we need to examine specialty moves, which may deliver an objective of consolidation but will also create capacity for emergency care at GRI and SGH. In the case of GRI this may include an early move of cardiothoracic surgery to the Golden Jubilee National Hospital (GJNH) as a first stage in the proposals to consolidate all West of Scotland cardiac surgery there, which are presently under development. In this regard and in terms of other potential capacity - we will seek early agreement with the GJNH on a partnership approach to management and facilities;
- the work underway by the Services, Beds and Capacity Sub Group of the ASR Programme Board to finalise the disposition of smaller specialties should be reframed to make recommendations on potential interim service moves as soon as possible but alongside clear proposals on the final disposition of services; this work covers vascular and other surgical subspecialties, urology and renal services;
- we need to work through, with senior clinical staff, how to put in place arrangements to avoid concerns over patterns of work, status, clinical leadership and management arrangements becoming blocks to achieving change. At headline level, the assumption should be that in consolidating services we have a level playing field approach that does not disadvantage the clinical staff from the service which is transferring;
- the two options outlined in Section 2 for the future of Stobhill after July 2005 should be worked up for public engagement;
- early consolidation will require the use of existing physical facilities and restrictions on the short term availability of capital plus the need for rapid progress will restrict the opportunities for substantial upgrading. It is therefore imperative that the early consolidation includes systematic review of other ways of improving patient care through improved organisation of services;
- in the light of the above, it is critical that the confidence in and credibility of the whole programme that the work to deliver the business cases for the new inpatient facilities is completed by the autumn of 2004 and we will therefore be extending the resources available to the Programme Director: Acute Services Implementation to ensure that the necessary capacity is in place to deliver this challenging timetable.

3.3 Our objective should be to have achieved the changes outlined above, at the latest, by the end of 2007, alongside the opening of £265 million of brand new ambulatory hospital facilities.

EMBARGOED UNTIL MEETING

D. CONCLUSION

4.1 The work outlined in the paper will enable us to bring forward proposals for service change which progress the delivery of the shape of services agreed in the Acute Services Review but ensure that we can provide effective and safe services until the final, major capital investment is in place.

4.2 The Capital Investment Strategy which underpins the Board Clinical Strategy set out how we would remodel and modernise Glasgow's acute healthcare infrastructure over the period from 20007 to 2012 by means of a four phased approach to capital investment and clinical redesign.

4.3 The first phase which is actively underway with capital investment business plans approved by the Scottish Executive in the Spring of 2003, sees the building of the new West of Scotland Cancer Centre at Gartnavel General Hospital and the replacement of the majority of the clinical services at the Victoria Infirmary and Stobhill Hospital campuses with new built Ambulatory Care Hospitals. The cost of these developments is some £265.million and will see these new clinical facilities brought into use during the second half of 2007.

4.4 The second phase of this investment programme sees the creation of the new Southside hospital within the grounds of the Southern General Hospital and this scheme sees the construction of some 900 new beds with supporting theatre and other clinical work accommodation and will allow from the closure of the remaining in-patient beds at the Victoria Infirmary and Mansionhouse Unit in the south of the city and replacement of all old Victorian accommodation in the grounds of Southern General Hospital. This scheme has a capital cost of approximately £250.million and will see the new clinical facilities come on stream from late 2009 early 2010.

4.5 Phase three sees a similar development on the Glasgow Royal Infirmary campus where we will build 400 new beds which will allow the replacement of the remaining clinical facilities at Stobhill and replacement of the remaining Victorian buildings at the Glasgow Royal Infirmary campus. This scheme which is hoped will be completed late 2010 early 2011 has an indicative capital cost of approximately £120.million.

4.6 Phase four the final completion of modernisation of Glasgow's acute hospitals sees the building of new facilities and refurbishments substantially existing facilities on the Gartnavel General Hospital complex and they are also providing modern healthcare facilities for the West of the city allowing the full closure of the Western Infirmary facility. This scheme which should see patients admitted to the facilities in the second part of 2012 has an indicative capital cost of £120.million.

4.7 Alongside the proposals in this paper we are:

- working with Argyll and Clyde to ensure their emerging clinical strategy is reflected in our final plans;
- completing the bed modelling and capacity planning to size and design the new inpatient facilities;
- developing proposals for the review of the assumptions which underpinned our decision to have two Accident and Emergency sites, by the autumn of 2004.

4.8 Finally, we have referred throughout this paper to the need to engage the public and other interests in this programme of work. All of the propositions which are likely to emerge have been subject to public consultation and ministerial approval, and the process which we design to ensure there is proper and full engagement needs to reflect that fact.

GGNHSB(M)04/7
Minutes: 92 - 109

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 17 August 2004 at 9.30 am

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P R E S E N T

Mr R Cleland (in the Chair)

Dr F Angell	Councillor R Duncan
Mr J Bannon MBE	Mr W Goudie
Mr J Best	Dr R Groden
Dr H Burns	Councillor J Handibode
Mr R Calderwood	Mrs S Kuenssberg CBE
Councillor J Coleman	Mrs R Kaur Nijjar
Councillor D Collins	Mrs J S Murray
Dr B Cowan	Ms A Paul
Ms R Crocket	Mr I Reid
Mrs R Dhir MBE	Mrs E Smith (to Minute 99)
Mr T A Divers OBE	Mrs A Stewart MBE

Councillor A White

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

Ms E Borland	..	Acting Director of Health Promotion (to Minute 108)
Professor I Greer	..	University of Glasgow (to Minute 108)
Mr J C Hamilton	..	Head of Board Administration
Mr J M Hamilton	..	Assistant Director of Finance (to Minute 108)
Mr D R McCall	..	Consultant in Dental Public Health (to Minute 99)
Mr A McLaws	..	Director of Corporate Communications
Mr W S Marshall	..	Secretariat Officer
Ms D Nelson	..	Communications Manager (to Minute 108)
Ms C Renfrew	..	Director of Planning and Community Care
Mr D Walker	..	Assistant Director of Director of Planning and Community Care (to Minute 99)
Mr J Whyteside	..	Public Affairs Manager (to Minute 108)

B Y I N V I T A T I O N (TO MINUTE 108)

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Dr B West	..	Chair, Area Medical Committee

ACTION BY

92. APOLOGIES AND INTRODUCTORY REMARKS

In the absence of Professor Sir John Arbuthnott who was on annual leave, the NHS Board agreed that Mr R Cleland should take the Chair.

Apologies for absence were intimated on behalf of Professor Sir J Arbuthnott, Mr T Davison, Mr P Hamilton, Mrs W Hull, Mr G McLaughlin, Mr A O Robertson OBE and Mr C Fergusson (Chair, Area Pharmaceutical Committee).

ACTION BY

93. CHAIRMAN'S REPORT

The Acting Chairman reported that the Chairman had attended the University of Glasgow/NHS Board Strategy Group on 30 July 2004 and that progress was being made on a number of issues. The University of Glasgow had appointed Professor D Barlow as its new Executive Dean of Medicine to replace Professor S K Smith.

The Acting Chairman also reported that the Chairman had attended the Centre for Population Health Board meeting on 4 August 2004. A number of agreed initiatives were now gaining momentum. The Minutes would be submitted to the NHS Board for information. **Head of Board Administration**

NOTED

94. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following:

(a) Accountability Review

The annual Accountability Review meeting between NHS Greater Glasgow and the Scottish Executive Health Department had taken place on 21 July 2004. The format of the meeting had followed that previously agreed where the Chief Executive of NHS Scotland and Members of the Department's Management Board had met with the NHS Board Chairman first and then with the representatives of the Area Clinical Forum, followed by a meeting with the Area Partnership Forum. The opportunity had also been taken to visit one of Glasgow's Addiction Services outlets. The main business meeting was held in the afternoon. Mr Divers advised that the meeting had been positive and it was expected that the Scottish Executive Health Department's report would arrive in about six weeks' time. The outcome of that report would include an action plan.

(b) Annual Statutory Meeting with Greater Glasgow Health Council

Mr Divers reported on the last statutory meeting to be held between the NHS Board and the Health Council. As usual, it had been a constructive meeting where perspectives were shared over a number of issues. Mr Divers took the opportunity of thanking the Health Council Members and others for their efforts on behalf of patients over almost 30 years and the positive contribution they had made in that time. Mrs Bryson thanked Mr Divers for his comments which were much appreciated.

NOTED

95. MINUTES

On the motion of Mr I Reid, seconded by Mr R Calderwood, the Minutes of the meeting of the NHS Board held on Tuesday, 20 July 2004 [GGNHSB(M)04/6] were approved as an accurate record and signed by the Acting Chairman.

96. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was circulated and noted.

NOTED

97. CHILD PROTECTION

A report of the Nurse Director [Board Paper No 04/48] asked the Board to note progress to improve NHS child protection arrangements within Greater Glasgow.

In December 2003, the Board had received a report on child protection which highlighted a number of major issues for the NHS particularly:

- Tackling child protection concerns where the patient was not the child.
- Sharing information with other agencies.
- Ensuring all NHS staff were aware of child protection issues.
- Ensuring clear systems to enable concerns to be raised and addressed.
- Delivering corporate leadership and commitment to child protection.

Ms Crocket advised that the report had highlighted the extent of the challenge facing the NHS to address these issues and had proposed the establishment of an NHS Child Protection Forum to be chaired by the Board's Nurse Director. The terms of reference had been agreed and the Forum had been established in February 2004. In its short lifetime, it had achieved steady progress and had identified a clear work plan. The Forum now had an extensive programme of work and by autumn it will have delivered:

- Clear, corporate leadership on child protection in all Divisions.
- Detailed Divisional action plans setting priorities for change, led by Nursing and Medical Directors.
- Information for all NHS staff about their responsibilities backed up by web based resources and training.
- Improved NHS input to Local Authority Child Protection Committees. The Forum was enabling the pursuit of a more consistent and co-ordinated way of relating to the five Local Authorities with whom it worked.
- More systematic NHS engagement in cases requiring multi-agency co-operation including a commitment and clear approach to the sharing of information.
- Co-ordinated NHS input into serious case reviews.

Ms Crocket advised that the NHS Child Protection Forum was working in liaison with a couple of major initiatives including the National Reform Programme and work with Local Authority colleagues. In 2002, the Scottish Executive had established a multi-agency reform programme with the aim of developing child protection arrangements across all the relevant agencies. A number of national standards had been established and currently work was ongoing with each Local Authority Child Protection Committee to develop multi-agency plans for the implementation of these standards. In connection with the multi-disciplinary inspection of child protection, the design of this process was underway and it was anticipated that a pilot approach would be developed by the end of the year. Guidance on the review of Child Protection Committees was expected imminently.

Since the NHS Child Protection Forum was established, the NHS representation on each Local Authority Child Protection Committee had been reviewed and revised. Each Local Authority Child Protection Committee had a detailed multi-agency action plan addressing all the recent child abuse inquiries and Government guidance. Ms Crocket emphasised the need to remind Ministers of the specific challenges facing Greater Glasgow and in particular Glasgow City. This was in the context of vulnerable children, particularly in respect of children affected by deprivation, drug and alcohol misuse. Glasgow had seven of the most deprived constituencies in Scotland and it was estimated within the city a minimum of 10,000 children were affected by parental drug misuse.

Ms Crocket concluded that a major issue was the very limited and fragmented specialist resources available to support child protection activity within the NHS and deliver on all of the challenges she had outlined. The NHS Child Protection Forum was, therefore, presently working on a proposal to put in place a single Child Protection Unit to improve and support child protection systems across the NHS. This Unit would also improve the NHS response to other agencies.

Councillor Collins welcomed the initiatives being undertaken and pointed out that Local Authorities had been heavily involved in child protection work since 1996. Much of this work had been undertaken in conjunction with local NHS services.

Mrs Kuenssberg congratulated Ms Crocket on the infrastructure being put into place to tackle child protection issues locally. It was certainly a challenge to get individual practitioners fully aware of their responsibilities particularly in relation to information sharing. There were certain legal implications to be considered in some child protection work and she wondered whether Managed Clinical Networks had a role to play within the infrastructure being adopted.

Ms Crocket advised that clinicians were aware that if they had any doubts regarding a vulnerable child then any information they had should be shared. Many clinicians involved in child protection activity were in regular contact with children's reporters and some were members of Child Protection Committees. A Managed Clinical Network had been set up for the West of Scotland and this was being led by Dr J Herbison at the Yorkhill Division.

Mrs Murray asked about training. Ms Crocket advised that the NHS Child Protection Forum had a training programme but at the moment it was prioritising in certain areas. She recognised the need to develop training capacity.

DECIDED:

That the Board note the progress to improve NHS child protection arrangements within Greater Glasgow and receive a further progress report in the early part of 2005. **Nurse Director**

98. WHITE PAPER "PARTNERSHIP FOR CARE" – SCHEME OF DELEGATION AND NEW COMMITTEE ARRANGEMENTS REVIEW

A report of the Chief Executive and the Head of Board Administration [Board Paper No 04/49] was submitted on the governance and Committee arrangements from 1 October 2004.

Mr Divers explained the background to this report. A set of transitional arrangements had been approved by the NHS Board in March 2004 to ensure the smooth and effective conduct of the NHS Board's business from 1 April to 30 September 2004 to allow time for the development of a fuller set of arrangements and structures to take account of the move to single system working. The transitional arrangements took account of the process required to finalise the Annual Accounts 2003/04 and the appraisals of senior managers on executive pay arrangements, both of which had now been completed.

NHS Quality Improvement Scotland (NHS QIS) had advised the NHS Board that it was carrying out an interim peer review of all NHS Boards in Scotland to provide an overview of progress to date on the development and implementation of governance frameworks. This review would cover four main areas comprising clinical governance, risk management, patient focus public involvement and single system working. This review would be in two phases. The first consisted of completion of a self assessment to be submitted to NHS QIS by 13 September 2004 together with a range of core policies and documents. The second phase would be a meeting with the Peer Review Panel on 8 December 2004 to discuss self assessment and core documents. A national report providing a base-line for future performance assessment reviews would be published in May 2005. The review by NHS QIS added focus and urgency to the establishment of governance fora and to the work of harmonising the arrangements for risk management throughout NHS Greater Glasgow.

Mr Divers took Members through the papers as follows:

<u>High Level Scheme of Delegation</u>

The NHS Board at its February 2004 meeting had approved a draft high level scheme of delegation which described the levels of responsibility of the NHS Board, the Divisions and the Corporate Management Team. It also agreed that further work be carried out in partnership to develop key aspects relating to human resources' matters.

The NHS Board had agreed to move formal meetings of the Board and the Performance Review Group to alternate months, on a two monthly cycle. For Annual Accounts purposes and to meet the Scottish Executive Health Department timescale, there would still require to be a NHS Board meeting in July.

In addition, Members had been keen to create more opportunities for dialogue between Members of the NHS Board and members of the public and staff. As a result of the non Executive Directors' meeting with the Chairman on 15 June 2004, Members' visits were being arranged, focussing on facilities which would be the subject of debate at future NHS Board sessions/meetings. The Annual General Meeting had been arranged for Thursday 23 September 2004 and consideration would be given to holding two further "open" meetings later in the financial year possibly in other parts of NHS Greater Glasgow (ultimately in each Local Authority area).

Scheme of Delegation – Human Resources

NHS Greater Glasgow had become a single employer on 1 April 2004 following the dissolution of the four NHS Trusts. The Area Partnership Forum was now established as the Board-wide vehicle for partnership and consultation; all major organisations with the exception of the British Medical Association now participated in its work which linked to the development and implementation of the Greater Glasgow Local Health Plan.

In order to strengthen the current arrangements for partnership working in support of single system development, it was proposed to create a Human Resources Forum which would have responsibility, at NHS Board level, for the negotiation of changes to terms and conditions of employment (where these were not nationally determined) and for the harmonisation of common interpretations of policies and terms and conditions across Greater Glasgow.

Mr Divers emphasised that discussions were progressing currently amongst staff-side organisations about the composition of the Human Resources Forum. The Area Partnership Forum could serve as the vehicle for handling any urgent issues in the interim.

Mr Divers pointed out that "Partnership for Care" was clear, however, that NHS Boards must not again become "command and control" organisations of the past. There would, therefore, continue to be devolved to Operating Divisions the major responsibility for the execution of the Human Resources function. Divisional Partnership Forums would continue as the main vehicles by which partnership working and consultation were delivered locally. The handling of employee conduct matters would continue to be discharged within Divisions, with Members of the NHS Board continuing to participate in Appeal Panel Hearings.

Within these principles, it was proposed that the finer details continue to be developed through a pan-Glasgow Partnership Agreement. The NHS Board had approved and had now embarked on recruitment of, a Director of Human Resources. The establishment of that post, allied to the other developments of the partnerships described, would support also the further strengthening of the staff governance arrangements within NHS Greater Glasgow.

Standing Financial Instructions (SFIs)

Mr Divers advised that this was a key component of the detailed Scheme of Delegation – NHS Boards' revised overarching Standing Financial Instructions detailed the financial responsibilities, policies and procedures for NHS Greater Glasgow. The Standing Financial Instructions incorporated the limits delegated to NHS Boards to instigate competitive tendering, write off losses and authorise special payments, schedule of authorised signatories and administrative delegation. The Standing Financial Instructions were considered by the NHS Greater Glasgow Audit Committee at its meeting on 9 March 2004 at which it was decided to recommend their approval to the NHS Board.

Future Committee Arrangements

The NHS Board had an initial discussion about future committee arrangements and the potential role of the governance fora at its seminar on 3 August 2004. In respect of those committees where the appointment of a new chair was required, notably, the Audit Committee, the Health and Clinical Governance Committee and the Research Ethics Governance Committee, the Board Chair should make the necessary arrangements to fill these positions.

In the light of discussion at the Accountability Review meeting, the NHS Board should review the role of the Area Clinical Forum with the chair and members of that group.

At the August Board Seminar, the Employee Director had made a presentation on the standard which set out for Board Members the extensive responsibilities which the Staff Governance Committee would carry in ensuring delivery of the standard.

It was proposed, therefore, that the Staff Governance Committee should develop over the next four months a three year action plan to address the requirements of the standard and to ensure that there was a clear process by which the Committee could monitor implementation of the agreed action plan. It would also be an opportunity to review the role of the Staff Governance Committee both to take stock of experience over its first two years and to reflect that the staff governance standard was now enshrined in legislation.

Following the seminar discussion, it was proposed that any changes to the remits of other Board committees should be debated first within those committees with recommendations for change taken forward by the Board as part of the ongoing programme of Board development.

Governance Fora – Divisional Level

At this seminar it had been agreed that:

- To exploit fully the existing assurance and risk management processes, the work of the Governance Fora could be incorporated into the regular business of the Divisional Management Team. It was recognised that existing arrangements for the organisation of the routine and operational aspects required to support financial, clinical and staff governance may need to be retained within each Division.

- To enable the Governance Fora to better discharge this assurance role, the Divisional Management Team should be augmented by the appointment of additional non Executive Directors. The finer details and appointments would be worked through as part of the Board's ongoing development programme and led by the Chairman.

- When acting as the Governance Forum, meetings of the Divisional Management Team should be chaired by a non Executive Director.

- It would normally be sufficient for the Governance Fora to meet quarterly.

These arrangements would allow the main planks of governance to be in place at 1 October 2004 while giving some further opportunity for refining aspects with the involvement of Board Members in the ongoing programme of Board development.

Councillor Collins referred to the need for a strict timetable for policy groups delivering their actions and the need to keep Members fully informed of the various changes as they arose. Mr Divers acknowledged this point and agreed to take stock of the relevant groups and actions to be tracked. Mrs Smith regarded the processes underway as the best "fit" given the size and complexity of NHS Greater Glasgow.

Mrs Stewart suggested that there should be a more uniform standard for the remits of the Standing Committees. Mr Divers acknowledged this point and would seek ways of addressing this particular point.

DECIDED:

(i) That this update on the Governance Committee arrangements proposed from 1 October 2004 be received and noted.

(ii) That the Standing Financial Instructions (SFIs) included as Annex 2 to this report be approved. **Director of Finance**

(iii) That the arrangements for the appointments to the Chairs of the Audit, Health and Clinical Governance and Research Ethics Governance Committees be approved. **Head of Board Administration**

(iv) That the broad arrangements for assuring governance at Division level, with the further details and appointment of Members to be worked through as part of the ongoing programme of Board development and led by the Chair be approved. **Head of Board Administration**

99. ORAL HEALTH STRATEGY 2004-2009 : CONSULTATIVE DRAFT

A report of the Director of Planning and Community Care [Board Paper No 04/50] asked the Board to approve the draft strategy for consultation and to agree to receive a final report based on that consultation at the Board's December meeting.

Mr Walker explained the background to the production of the Oral Health Strategy for 2004-2009. Oral health was currently the subject of much national attention. Responses from the Scottish Executive were expected in the autumn to major consultations on "Improving the Oral Health of Children" and "Modernising NHS Dental Services in Scotland". The Board had previously commented on both of these consultation documents. The responses of the Scottish Executive Health Department would shape the future national framework for the delivery of dental services and determine the prospects for better oral health. The proposed Oral Health Strategy for Greater Glasgow had attempted to anticipate the outcome.

Mr Walker pointed out that there were a number of key pressures affecting oral health within Greater Glasgow. Greater Glasgow's oral health was poor. For all the principal age groups, Greater Glasgow exhibited poorer oral health than almost anywhere else in Scotland which in turn had one of the poorest oral health records in western Europe. Whilst there were some signs of improvement, these were occurring at a slower rate than in other areas. The prevalence of dental caries amongst five year old children in Greater Glasgow continued to be a cause of concern.

Within Greater Glasgow there were substantial inequalities in terms of levels of oral health, where geographically there was a direct relationship with poverty and deprivation. Access to dental services, with many marginal groups, for example, older people in care, homeless people and children with special needs, receiving limited support in terms of treatment, care and prevention, again directly related to disadvantage.

Mr Walker pointed out that oral health mirrored the pattern of Greater Glasgow's general ill health with Glaswegians having a poor attitude towards their own health in general. Compared with the rest of Scotland, Greater Glasgow had amongst the highest numbers of NHS dentists per population and the highest rates of registration with a dentist and yet its oral health record was amongst the poorest. Of expenditure on oral health in Greater Glasgow, 88% was spent on general dental services yet, because of the limitations of the present GDS contract, this spending conspired with other factors to leave major gaps in provision. Unlike general medical services, the alternative public service option was limited in oral health with the Community Dental Service being proportionately smaller than in other areas of Scotland.

Mr Walker advised that the vision for oral health in Glasgow was that "healthy mouths matter in Greater Glasgow. Good oral health will be valued as part of healthy living. Everyone will have healthy mouths and be able to maintain them".

To deliver this vision, the Oral Health Strategy was built on the following core principles:

- Reducing inequalities.
- Integrated working in pathways.
- Evidence based practice.
- Making oral health everybody's business.
- Making oral health integral to holistic health.

The success of the strategy would depend on the implementation of a number of critical and inter-relating factors. These included:

Partnership Working

Improvement in oral health would depend not just on dentists. The delivery of the strategy would rely on the close working, co-ordination and leadership of a wide range of primary care professionals, including dental nurses, therapists, hygienists and health promoters as well as dentists, general medical practitioners and health visitors. Better integration was necessary also with secondary care, notably with Glasgow Dental Hospital and School.

Service Change

A number of important dental services could be expected to change significantly over the lifetime of the strategy. These included the potential for resiting of the Glasgow Dental Hospital and School, meeting waiting time targets for dental specialties, delivering on national plans for dental training, relocating and streamlining the Child Dental General Anaesthesia Service, redesigning the Oral and Maxillofacial Service and responding to a new national contract for General Dental Practitioners. It was vital that all of these changes were consistent with the aims and objectives of the Oral Health Strategy.

Leadership

A key issue to be tackled was that of water fluoridation. The strategy identified this as the single most effective measure that could be taken to counter dental decay. The strategy also acknowledged that it was a highly contentious issue which was likely to take at least five years to implement even within a favourable or permissive national policy environment. Consequently, the strategy advocated a range of other measures, some were exclusive to oral health others shared with other strategies.

Resources

The strategy required that existing resources would be used to better effect in the future and it also required further investment if Greater Glasgow's oral health was to be significantly improved. Specific measures had been identified within the strategy which were realistic and were indicative of the need for a fairer recognition for oral health issues.

Mr Walker concluded that this was a five year strategy which if put fully in place would go a long way to enabling Greater Glasgow to meet the national targets. The performance of the strategy would be reviewed annually and possibly rolled out as part of the Performance Assessment Framework (PAF) within the Accountability Review process. The consultation process was being structured to reflect the underlying philosophy of the strategy, that is, that oral health was everyone's business. The consultation process would be structured, targeted and interactive and the intention was to report back on its outcome at the December meeting of the Board.

Both Mrs Dhir and Mrs Stewart raised concerns regarding the fluoridation of the public water supply. Dr Burns pointed out that the scientific evidence was robust in that fluoridation of the public water supply was the single most effective measure that could be taken to counter dental decay. He acknowledged that there may be other issues involved in fluoridation which were of a more ethical nature but from the purely medical point of view it was a proven health benefit.

Dr Angell made a number of points in relation to the content of the Oral Health Strategy and pointed out that registration with a General Dental Practitioner was for a 15 month period whereas for a General Medical Practitioner is was usually for life. He alluded to the long waiting lists for specialist dental services and the need for additional staff.

Councillor White referred to the disparities in funding between areas of social deprivation and more affluent areas within Greater Glasgow. Mr Walker acknowledged these disparities but pointed out that they were generally a reflection of where dentists chose to set up their practices. However, he was hopeful that the establishment of a unified salary service would help to alleviate such disparities in the future. The benefits of community planning and the need for oral health to be part of that process were acknowledged.

Mrs Murray welcomed the Oral Health Strategy but questioned the practicality of establishing tooth brushing programmes within primary schools. Mr Walker acknowledged this point but emphasised the need to have the importance of oral health registered with children and teachers through the auspices of School Health Teams.

DECIDED:

(i) That the draft Oral Health Strategy 2004-2009 be approved for consultation. **Director of Planning and Community Care**

(ii) That a revised Oral Health Strategy based on the outcome of that consultation be submitted to the December meeting of the Board be agreed. **Director of Planning and Community Care**

100. UPDATE ON KIRKINTILLOCH INITIATIVE PARTNERSHIP AGREEMENT WITH EAST DUNBARTONSHIRE COUNCIL

A report of the Chief Executive of the Primary Care Division [Board Paper No 04/51] asked the Board to re-affirm its commitment to the partnership between East Dunbartonshire Council and Greater Glasgow NHS Board as enshrined in the Kirkintilloch Initiative Partnership Agreement.

Mr Reid explained the background to this issue. At its meeting on 18 December 2001 the Board had approved the former Greater Glasgow Primary Care NHS Trust's partnership agreement with East Dunbartonshire Council to promote the socio-economic regeneration of Kirkintilloch. This partnership was known as the Kirkintilloch Initiative and its legal structure and form were documented in the partnership agreement.

During the course of the last three years, the partnership has progressed many key issues such as securing planning consents for a number of key projects. The partners had developed the project plans and proposals within the context of East Dunbartonshire Council's local plan framework. The draft local plan which updated the extant local plan necessitated a review of the Initiative's proposals. The review had, in turn, resulted in a number of changes to the partnership agreement.

Mr Reid took Members through progress to date and the key points of the draft revised partnership agreement. The Scottish Executive had already approved the original partnership agreement and assuming NHS Board and East Dunbartonshire Council approvals, the intention was to submit this revised partnership agreement to the Scottish Executive for affirmation of their approval.

Councillor Duncan thanked the key players involved in drawing up the Initiative partnership agreement and suggested that it was a very good example of what community planning and working together could deliver. He pointed out that East Dunbartonshire Council were fully supportive of the draft revised partnership agreement as outlined in the paper submitted to the NHS Board.

DECIDED:

That the Board's commitment to the partnership between East Dunbartonshire Council and Greater Glasgow NHS Board, as enshrined in the Kirkintilloch's Initiative Partnership Agreement, be re-affirmed. **Chief Executive, Primary Care Division**

101. PUBLIC HEALTH ISSUE – GREATER GLASGOW NHS BOARD CERVICAL SCREENING PROGRAMME – ANNUAL REPORT 2002/2003

A report of the Director of Public Health [Board Paper No. 04/52] asked the Board to note Greater Glasgow NHS Board Cervical Screening Programme Annual Report for 2002/2003.

The Director of Public Health pointed out that each year NHS Boards were required to provide a report on the activity and outcomes of the cervical screening programme in their area. Cervical cancer was a relatively uncommon cancer but it was easily detected in a pre-malignant stage when pre-cancerous cells could be treated, preventing the subsequent development of an invasive malignancy. Over the years, a progressive decline in cervical cancer mortality has been noted in Scotland, confirming the success of the cervical cancer screening programme.

The Director of Public Health pointed out that the latest report presented information about all the different components of the programme. During the financial year 2002/03, 74,631 women between 20 and 60 years of age were screened. The overall 5.5 year screening uptake was 82% (uptake was measured within sequential 5.5 year periods since this was agreed as the time limit within which women should be invited and should attend for smears). As in previous years, uptake varied by deprivation category, falling from 89% in deprivation category 1 to 78% in deprivation category 6. 73% of NHS Greater Glasgow general practices had a 5.5 year screening update of at least 88%.

The Director of Public Health advised that three major issues had dominated the cervical screening programme during the period April 2002 to March 2003; the review of the screening programme by NHS Quality Improvement Scotland; the introduction of liquid based cytology and work undertaken to improve uptake of screening in specific areas of Greater Glasgow NHS Board. These initiatives were all discussed in detail within the report.

In response to a reference made to the number of General Practitioners undertaking their own cervical smear screening programmes, Dr West emphasised that there was no evidence of any worst outcomes as a result. The Director of Public Health acknowledged this point. Dr West referred specifically to a point made in the report which showed that women aged 20-29 years had the highest percentage of abnormal smears. She pointed out that in England women did not present for a smear until they were 25 years of age. The Director of Public Health acknowledged this point but emphasised that the current arrangements within Scotland were working well and should remain.

In response to questions from Mrs Dhir regarding non-attenders, Dr Burns pointed out that a failsafe system was in operation. Non-attenders or patients with abnormal smears were very quickly followed up. Regarding the promotion of the cervical screening programme, the various leaflets and videos which had been produced were specifically targeted at those practices with low uptakes.

DECIDED:

That the GGNHSB Cervical Screening Programme – Annual Report for 2002/2003 be received and noted. **Director of Public Health**

102. MEMORANDUM OF UNDERSTANDING BETWEEN NHS GREATER GLASGOW AND THE UNIVERSITY OF GLASGOW ON THE CONDUCT OF CLINICAL TRIALS

A report of the Director of Public Health [Board Paper No. 04/53] asked the Board to approve a draft Memorandum of Understanding between the University of Glasgow and NHS Greater Glasgow on the conduct of clinical trials within the Board's area.

Dr Burns advised that on 1 May 2004 new regulations had come into force which changed the legal framework within which clinical trials on medicines took place. These new regulations implemented in the United Kingdom the European Union Clinical Trials Directive 2001/20. The new regulations clarified specific legal duties of the various sponsors and investigators in clinical trials of medicines and the regulations were based on internationally agreed principles.

The regulations did not alter the responsibilities and potential liabilities of researchers or of the NHS. The Department of Health and UK Universities had sought to reassure the service that these new regulations did not change the underlying allocation of responsibilities and potential liabilities in clinical trials, rather they sought to remind all participants of the need for continuing high standards in clinical research governance.

The Memorandum of Understanding agreed between NHS Greater Glasgow and the University of Glasgow had been reviewed by the Central Legal Office and the document incorporated some minor amendments suggested by them.

Dr Burns advised that the only additional burden imposed on the Board by the arrangements would be the establishment of a register. However, since such events were rare it was not anticipated that this would involve a great deal of work for the participants.

In response to a question from Mrs Kuenssberg, Dr Burns advised that the Memorandum of Understanding was solely between the University of Glasgow and NHS Greater Glasgow. There were no plans at the moment to enter into any such arrangements with either Glasgow Caledonian University or the University of Strathclyde since their research arrangements were of a different type.

DECIDED:

That the draft Memorandum of Understanding between the University of Glasgow and NHS Greater Glasgow on the conduct of clinical trials within the Board's area be approved. **Director of Public Health**

103. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 04/54] asked the Board to note the progress on meeting waiting time targets.

NHS Greater Glasgow was currently sustaining the nine month guarantee and over six month waits reduced by 54 (3%) between June and July 2004. Ms Renfrew pointed out that this progress had been sustained against the backdrop of a holiday period.

NOTED

104. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 04/55] asked the Board to approve the following Medical Practitioners employed by the Primary Care Division of NHS Greater Glasgow to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984:

Dr David Johnson
Dr Selwyn McIlhinney
Dr Anupam Agnihotri
Dr John Prestwich
Dr Jacqueline Wiggins
Dr Rebecca Philip
Dr Sheila Flett
Dr Diane Forsyth
Dr Olwyn Gallagher

DECIDED:

That the above named Medical Practitioners be approved and authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984 **Director of Public Health**

105. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES

The Minutes of the Health and Clinical Governance Committee held on 27 July 2004 [HCGC(M)04/3] were noted.

NOTED

106. RESEARCH ETHICS GOVERNANCE COMMITTEE MINUTES

The Minutes of the NHS Greater Glasgow Research Ethics Governance Committee held on 12 July 2004 [NHSGGREGC(M)04/1] were noted.

NOTED

107. PERFORMANCE REVIEW GROUP MINUTES

The Minutes of the Performance Review Group held on 15 July 2004 [PRG(M)04/4] were noted.

NOTED

108. EXCLUSION OF PUBLIC AND PRESS

On the motion of the Acting Chairman, seconded by Dr B Cowan, it was -

DECIDED:

That the public and press be excluded from the remainder of the meeting in view of the confidential nature of the business to be transacted.

109. PROPOSED DISPOSAL OF ROADWAYS AT ROBROYSTON

A report of the Director of Planning and Community Care [Board Paper No 04/56] asked the Board to agree the recommendation of the NHS Board's Property Adviser to dispose of the solum of various private roads running through the former Robroyston Hospital grounds, which were omitted from the original sale of those grounds in the 1970s and to accept the price and terms and conditions of the sale as offered by the proposed purchaser.

Ms Renfrew advised that the report summarised the reports and advice given by the NHS Board's Property Adviser and an Independent Valuer in relation to the disposal of roadways at Robroyston. Greater Glasgow Health Board as it was then sold the former hospital at Robroyston in the 1970s. It had transpired, however, that not all of the Health Service ownership at Robroyston had been sold but the solum of various private roads running through the estate were excluded.

DECIDED:

That the recommendation of the Property Adviser to dispose of the solum of various roads at the former Robroyston Hospital, on the terms and conditions offered by the proposed purchaser, be approved.

Director of Planning and Community Care

The meeting ended at 11.20 am

GGNHSB(M)04/9
Minutes: 127 - 149

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 21 December 2004 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Bannon MBE
Mr J Best
Dr H Burns
Mr R Calderwood
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B Cowan
Ms R Crocket
Mr T P Davison
Ms R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie
Dr R Groden
Mr P Hamilton
Mrs W Hull
Mr G McLaughlin
Mrs J S Murray
Ms A Paul
Mr I Reid
Mr A O Robertson OBE
Mrs E Smith
Mrs A Stewart MBE
Councillor A White

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

Dr S Ahmed	..	Consultant in Public Health Medicine (for Minute 138)
Mr A Bishop	..	ECCI Project Manager (for Minute 134)
Ms E Borland	..	Acting Director of Health Promotion
Ms J Frame	..	Programme Manager (for Minute 134)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Ms S Laughlin	..	Women's Health Co-ordinator (to Minute 137)
Mr A McLaws	..	Director of Corporate Communications
Ms D Nelson	..	Communications Manager
Ms C Renfrew	..	Director of Planning and Community Care
Mr J Whyteside	..	Public Affairs Manager

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Mr C Fergusson	..	Chair, Area Pharmaceutical Committee
Mr H Smith	..	Chair, Area Allied Health Professionals Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

127. APOLOGIES AND INTRODUCTORY REMARKS

Apologies for absence were intimated on behalf of Councillor J Handibode, Mrs S Kuenssberg CBE, Mrs R K Nijjar, Professor I Greer, Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Ms G Leslie (Chair, Area Optometric Committee).

ACTION BY

Mr J C Hamilton referred to the nomination process for the appointment of Vice Chair of the Board. One nomination was received, that of Mr Andrew Robertson. Dr Angell proposed and Mrs Stewart seconded Mr Robertson's nomination.

DECIDED:

That Mr A O Robertson be appointed Vice Chair of the NHS Board.

Sir John advised the Board that Elinor Smith had been appointed as Chair of NHS Greater Glasgow Audit Committee. He also congratulated the NHS Board's Director of Finance, Wendy Hull, on her recent appointment as Director of Finance to a large Acute Trust in England.

Sir John took the opportunity to thank NHS Greater Glasgow's 33,000 members of staff for delivering an excellent service across the city throughout 2004. This had included around five million primary care contacts, three hundred thousand inpatient/day care cases (acute) and two and half million outpatient attendances. He commended everyone's efforts in achieving the service offered to patients.

128. CHAIRMAN'S REPORT

The Chairman updated on the following:

(a) The Minister for Health and Community Care, Andy Kerr, this week announced a new plan for NHS Scotland entitled "Fair to All, Personal to Each" which aimed to substantially cut waiting times over the next three years. Mr Divers would provide further detail of this new plan during his Chief Executive's update.

(b) Professor Andrew Calder, whom the Minister had appointed as Chair of the Advisory Group to consider the future location of a new children's hospital in NHS Greater Glasgow, was currently clarifying the membership of his Group and its working arrangements with the Minister. Sir John envisaged a further update on progress in early 2005.

(c) Sir John had accepted a petition prior to the beginning of the Board meeting objecting to any closure of inpatient beds at Glasgow Homoeopathic Hospital. He confirmed that an evaluation of the hospital's services was ongoing as were the various strands of work the NHS Board had previously agreed to.

(d) The Joint Strategy Group with the University of Glasgow now met regularly and had established subgroups to take forward key areas of joint work. This was proving to be an excellent platform for progressing joint work.

(e) Sir John was a member of the Workforce Committee looking at workforce issues throughout NHS Scotland. It was their intention to create a robust model looking at the supply and demand of the workforce across Scotland against the background of the Scottish economy.

NOTED

129. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following:

(a) "Fair for All, Personal to Each", a new plan announced by the Minister for Health and Community Care, brought in a range of new waiting times targets for the service, many of which represented a considerable advance on existing targets. All of the targets announced in the plan were to be achieved by the end of 2007 and Mr Divers summarised these as:

- An eighteen week maximum wait for both outpatient and inpatient or day case hospital treatment. This extended and expanded the existing target of a maximum wait of six months for each by the end of 2005.
- A specific target for cataract surgery of eighteen weeks from referral to surgery.
- A four hour maximum wait from arrival at A & E until admission, discharge or transfer. This matched the existing target for the NHS in England.
- A twenty-four hour maximum wait for surgery following a hip fracture.
- The existing target of a maximum sixteen week wait for cardiac intervention was expanded to include the period following GP referral and to cover a wider range of treatments, including heart valve surgery.
- Further new waiting targets for diagnostic tests would be announced in Spring 2005.

Mr Divers concluded by confirming that the NHS Board was working towards detailed capacity plans to deliver these standards.

(b) Robert Calderwood, Catriona Renfrew and himself had met with counterparts in NHS Lanarkshire to discuss the regional dimensions of Lanarkshire's strategic document "A Picture of Health". They had taken the opportunity of picking up mutual topics of interest to ensure they worked together in parallel in taking forward their strategic planning.

(c) Mr Divers asked Mr Calderwood to clarify the position in relation to Accident and Emergency Services as an article had appeared recently in the Evening Times which may have led to confusion. Mr Calderwood advised that there had been no change to the Board's strategy in relation to A & E services and that the two monitoring groups (set up by the then Minister of Health and Community Care) met regularly to monitor the planned services at both Stobhill and the Victoria Infirmary. In addition, work was going on with the Royal Colleges to try and address training issues for junior doctors at Stobhill and the outcome of these discussions would be reported to the NHS Board when the discussions had concluded.

NOTED

130. MINUTES

On the motion of Mr G McLaughlin, seconded by Mr A O Robertson, the Minutes of the meeting of the NHS Board held on Tuesday, 12 October 2004 [GGNHSB(M)04/8] were approved as an accurate record and signed by the Chairman pending the following amendment:

Page 3, Item 12 (b), line 5, delete "Rankin" and insert "Brankin".

131. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was circulated and noted. Mr J C Hamilton updated Members on issues which had progressed since the publication of the Rolling Action List.

NOTED

132. CONSULTATION PAPER : IMPLEMENTING PARTNERSHIP FOR CARE – THE NEXT STEPS

A report of the Chief Executive [Board Paper No 04/63] asked the Board to receive a consultation paper which set out the next steps proposed in implementing "Partnership for Care" and approve the issue of the paper, following consideration by the Board, to consultees.

In describing the next steps which the NHS Board proposed to take in implementing "Partnership for Care" Mr Divers advised that he had delivered presentations to four NHS Board seminar sessions, the Area Partnership Forum, over one hundred senior staff, professional advisory committees including the Area Clinical Forum, the GP Subcommittee and a series of meetings with representatives from Local Authorities. Over and above this, many briefing sessions had taken place at Divisional level.

He described the remaining aspects of the proposed organisational changes on which consultation had not yet taken place and summarised those areas where approval had already been granted by the Board following consultation. He described the context of the new organisational arrangements proposed and stressed, at the outset, the "Partnership for Care" priority which was to improve health and narrow the inequalities gap. He described how the Board was committed to strengthening the interface between the primary and secondary care sectors and how the organisational arrangements with the creation of CHPs and the proposed Acute Operating Division would specifically address this, both in the design of the respective structures, with appropriate cross-representation and in the development of shared objectives for senior managers working within the respective structures. In setting the scene for the next steps in moving fully into single-system working in NHS Greater Glasgow, Mr Divers detailed the new organisational arrangements in the context of "Partnership for Care" and noted the key outcomes which each part of the system would be expected to deliver. He led the Board through four schematics as follows:

- The formal Subcommittee structure which reflected the three key planks of governance as stipulated in "Partnership for Care" – corporate (audit/risk management), health/clinical and staff governance.

- The key dynamics and interactions which were designed to secure delivery both of corporate functions and of involvement therein of colleagues from other parts of the new structure.

- The potential acute services structure.

- The proposed Directorate of Rehabilitation and Enablement.

The focus of the public consultation was to move away from the current structure of four Operating Divisions to a new arrangement. Alongside this consultation, the detailed work of designing the new structures would be taken forward with full staff and staff partnership involvement. Mr Reid had drafted a paper on "Managing the Transition" which set out the key principles by which the process would be managed – this re-enforced the commitment to a partnership approach, the application of the policy of "no detriment", an assurance that there would be no compulsory redundancies, a commitment to communicate with all directly affected staff as soon as possible when the details of structural arrangements became clear, and, whenever possible, to match any displaced individuals to new posts but, where competition was necessary, to endeavour to ensure that the number of interviews for any one individual was kept to a minimum.

It was intended to issue the consultation paper as quickly as possible following the NHS Board meeting and comments from consultees on all aspects of the consultation paper were welcome. As the specific issues for consultation were relatively few, it was proposed that the consultation run for just over six weeks allowing the NHS Board to consider the responses and make decisions at its February 2005 Board meeting.

This was bearing in mind that the start date for implementing the new arrangements was from 1 April 2005. That date signalled the move into the new arrangements; the expectation was that implementation would progress steadily through the 2005/2006 year as the new organisations developed their capacity to deliver the different roles which they would discharge. It would be important, however, in order to guard against a loss of momentum in continuing to take forward the Board's key priorities for action to keep the period during which competition for posts was carried out as short as possible so that uncertainty for staff was kept to a minimum.

Councillor Collins welcomed the spirit of the consultation and recognised the much work that was in progress. In recognition of many of the issues to be worked through with Local Authorities and given the Christmas and New Year holiday period he wondered if this complex process would merit from a longer consultation period rather than a short six week period.

In response to this, Mr Divers outlined key planks of the proposals which had already been subject to consultation. He re-emphasised that this would be a gradual process of implementation. Given this and the other work which was being handled with Local Authorities and that the anticipated audience would be largely limited to the NHS, a relatively short consultation process seemed feasible.

Mr Robertson recognised the point made by Councillor Collins and sought clarification around what audience the consultation document was aimed at. He also referred to some areas in the paper which would require refining prior to it going out to consultation and sought clarity around where diversity and anti-discrimination work would fall. Referring to the diagram shown at paragraph 5.7 of the paper, it was not clear how the acute services planning team tied in with the acute services structure.

In response to a question from Mr Cleland, Mr Reid advised that the Staff Governance Committee would play a key role in taking forward the implementation arrangements and would receive regular reports on the process and how it was being managed. It was envisaged that the Staff Governance Committee would approve the overall process as, at the moment, the Area Partnership Forum had agreed most of the principles and had set up a Sub-group looking at the ramifications for CHPs. As such it was anticipated that the Staff Governance Committee would be the vehicle for approving the implications for staff.

In light of this, Mr McLaughlin recommended that the Board prioritise its HR structure as early as possible to ensure that this support was in place to progress the process of change successfully.

Councillor Collins referred to the Board paper on the agenda which was looking at Community Health Partnerships and their Model Scheme of Establishment. He saw many interlinking areas between the two papers and although both had different end points, there were many areas of joint working between the two.

Councillor White re-iterated that the six week consultation period may be rather tight time. Mr Divers suggested that the February NHS Board meeting scheduled for Tuesday 15 February 2005 could be put back a week to Tuesday 22 February 2005 and the closing date for comments be extended to 14 February 2005. This was agreed.

Mr McLaws confirmed that the Communications Team had drafted an information leaflet for patients and staff summarising the consultation document.

DECIDED:

(i) That the consultation paper which set out the next steps proposed in implementing Partnership for Care be received. **Chief Executive**

(ii) That the paper be issued, following the suggested amendments being made, to consultees and the outcome reported to the Board meeting re-scheduled for Tuesday 22 February 2005. **Chief Executive**

133. COMMUNITY HEALTH PARTNERSHIPS : PROGRESS REPORT AND MODEL SCHEME OF ESTABLISHMENT

A report of the Director of Planning and Community Care [Board Paper No 04/64] asked the Board to note work in progress in establishing Community Health Partnerships (CHPs) and their Schemes of Establishment to be submitted to the Scottish Executive Health Department by December 2004.

Ms Renfrew described the NHS Board's objectives for CHPs and how these aspirations and objectives had driven the work in developing Schemes of Establishment with each Local Authority. The purpose of the model scheme was to provide a framework within which the detailed work with Local Authorities was being undertaken so that there was a degree of consistency on key principles. This had also enabled the NHS Board to engage with key professional interests and to ensure the NHS CHP Steering Group, which included substantial partnership representation, had been fully involved in discussing key policy issues.

During the development of national guidance and regulations in relation to CHPs, NHS Greater Glasgow had consistently sought to ensure that there was flexibility to construct the organisation and governance of CHPs to reflect the extent to which they were full partnerships with Local Authorities rather than a relatively limited NHS organisation. Ms Renfrew advised that the final guidance and exchanges with the Scottish Executive Health Department indicated that this flexibility was potentially available.

Ms Renfrew went on to briefly outline the position as it stood currently with each Local Authority and she described further work required to finalise the Schemes of Establishment. It was hoped to finalise the Schemes of Establishment for Board and Local Authority approval during January 2005 for submission to the Scottish Executive Health Department by the end of that month. There would also be a further round of dialogue on the migration arrangements for services and functions presently managed by the Primary Care Division (PCD), the outcome of which would illustrate how the highly effective operation of the PCD would be delivered in the revised working arrangements. It was recognised that the substantial change which CHPs represented alongside the rest of the NHS re-organisation meant that, although aiming for establishment at April 2005, there would need to be a coherent programme of development and migration of responsibilities over the following twelve months.

Councillor Collins referred to the work ongoing with East Renfrewshire Council and sought clarity, in particular, around the agreement that children and families Social Work be included within the CHP. Mr Divers confirmed that this could be picked up at the meeting taking place that afternoon with representatives from East Renfrewshire Council.

Councillor White re-iterated that any re-organisation should be about improving the services provided to patients and therefore it was important that close working relationships be fostered between the NHS Board and Local Authorities recognising the close service arrangements already in place. Mr Robertson and Dr Groden both welcomed the amended report and commended the revisions that had been made which had clarified many of the concerns already raised. He also agreed with Ms Renfrew's earlier point that April 2005 was the start of a journey and should not be seen as a definitive end of many good ways of working with the PCD and at LHCC level.

Ms Dhir was unclear what areas of delegation Local Authorities would bring to a CHP. Ms Renfrew clarified that these roles had yet to be defined as they had not been signed off yet at Local Authority level and they would differ across the CHPs in NHS Greater Glasgow.

Ms Borland welcomed the renewed emphasis on health improvement and encouraged that the officer designated to lead health improvement in CHPs should be a member of the CHP senior management team and in a position to provide advice and guidance on health improvement matters directly to the CHP board; that he/she should be required to be competent in terms of the national competencies for public health specialists and practitioners and that the Schemes of Establishment should allow for appropriate linkages and reporting arrangements between core health improvement staff in CHPs and elsewhere in the Greater Glasgow NHS system, as part of a cohesive and coherent health improvement effort.

In response to a question from Mr McLaughlin, Ms Renfrew confirmed that Ms Crocket and Dr Cowan were leading on work on clinical governance and that this included CHP clinical governance.

NOTED

134. ICT STRATEGY REFRESH 2004-2007

A report of the Director of Finance [Board Paper No 04/66] asked the Board to:

- endorse the ICT Strategy, 2004-2007;
- confirm the existing minimum fund of £2m per annum from capital funds;
- support the Project Management and wider resourcing issues set out in the Strategy;
- confirm the timetable set out in the Strategy.

Ms Hull restated NHS Greater Glasgow's ambitions to see technology as a major lever for change and modernisation in the way in which all patient services were delivered, in both hospitals and primary care.

The tasks set out in the initial ICT Strategy, 2002-2004, had been comprehensively achieved and as a consequence much of the technical and cultural infrastructure was now in place to realise the vision set out in the refreshed Strategy, 2004-2007. This vision clearly mirrored the National eHealth Strategy, which similarly saw the need to ensure that the culture was right to exploit to the full, the technology available. In commenting on NHS Greater Glasgow's approach, Peter Collings, Director of Performance Management and Finance, Scottish Executive Health Department, endorsed the progress made and confirmed that the two key components of the National Requirements had been well reflected in Glasgow's approach; those being:

- To ensure that the CHI number was universally used to uniquely identify all patients; and

- That national procurements should be undertaken and adopted locally for all major IT systems and applications.

Mrs Hull welcomed Alistair Bishop who was leading on the Electronic Clinical Communication Implementation (ECCI) Project and Joanne Frame who was leading on eMedicines Management.

Mr Bishop reiterated the importance in improving the way NHS Greater Glasgow held and shared information and the challenges associated with this. He discussed the electronic care record which would be available to all authorised staff (doctors, nurses, AHPs etc) via the Enterprise-wide Clinical Portal. This would provide a single log-on access to multiple sources of data about each patient and a user friendly means of navigating and organising patient information that could be tailored to specific clinical teams' requirements but retaining a common look and feel across all Glasgow sites. Of paramount importance was correctly identifying people and the use of the Community Health Index (CHI) number which was unique to each patient across Scotland.

Ms Frame re-iterated that the vision would only be achieved by getting both the technical environment and, more crucially, the clinical and cultural environment fit for purpose. Major investment in technology alone would not create the e-clinician; only the right attitude would as e-attitude embraced, with willingness and confidence, a need to be skilled in using technology, a desire to work in a more modern way and an approach that accepted working differently, more flexibly, to realise the benefits from investment in new technology.

Dr Groden re-enforced the value of the ICT Strategy and how the vision needed to incorporate the processes associated with getting the e-attitude and e-technology right as fundamental to delivering the effective e-clinician.

Ms Dhir asked if the Project Team had sought any comparisons with others of this scale and Mrs Hull confirmed that they had consulted with a similar project in Canada with whom they kept in touch. Furthermore, she clarified that the structure to support implementation of the overall Strategy although a new structure would be with existing staff who currently worked throughout the Divisions and at the NHS Board. Sir John thanked Mr Bishop and Ms Frame for attending and noted the many benefits from the ICT Strategy and the importance of it fitting in to the overall change programme within NHS Greater Glasgow at this very exciting time.

DECIDED:

(i) That the ICT Strategy, 2004-2007 be endorsed. **Director of Finance**

(ii) That the existing minimum fund of £2m per annum from Capital Funds be confirmed. **Director of Finance**

(iii) That the project management and wider resourcing issues set out in the Strategy be supported. **Director of Finance**

(iv) That the timetable set out in the Strategy be confirmed. **Director of Finance**

135. 2004/05 MID YEAR REVIEW

A report of the Director of Finance [Board Paper No 04/65] was submitted setting out the mid year review of the financial position for 2004/05.

Mrs Hull advised that, relative to the financial challenge and agreed in year financial plan, the Board was making good progress at the mid year point in 2004/05. Divisions were able to forecast breakeven at the year end against both operational budgets and Recovery Plan targets and she led the Board through a detailed position of each Division.

In terms of the waiting times non-recurrent funding requirements, these could be met from a combination of the 2004/05 capital and land sales. Nonetheless, the remaining deficit gap was £9m which would still leave a year end position of £4.6m deficit for 2004/05 to be carried non recurrently into 2005/06. As a result, it remained crucial that a combination of further in-year recovery plan savings were identified and strict continuation of monitoring of vacancy and other cost pressures was maintained. Mrs Hull stated that the NHS Board remained too reliant on non-recurrent funding and needed to move in 2005/06 to identify recurrent savings to lead to a break even position.

In response to a question from Mr Goudie in respect of the new pay arrangements under Agenda for Change (due to be implemented from October 2004), Mrs Hull recognised the challenges that lay ahead but commented that service change was at the heart of meeting this challenge.

DECIDED:

- That the 2004/05 Mid Year Review position as continuing to forecast a year end deficit of £4.6m be confirmed. **Director of Finance**

- That the Corporate Management Team be asked to further review opportunities in year for added savings to reduce the remaining deficit gap. **Director of Finance**

- That the Corporate Management Team be asked to continue to maintain strict vacancy management and other cost control measures in year. **Director of Finance**

- That further financial monitoring reports for the remaining months of 2004/05 be received. **Director of Finance**

- That the immediate implications for the 5 Year Financial Plan, 2005/06 to 2009/10, ahead of its detailed consideration be noted. **Director of Finance**

136. IMPROVING CORPORATE POLICY TO ADDRESS INEQUALITY ISSUES

A report from Ms Rani Dhir, Non Executive Board Member, Sue Laughlin, Women's Health Co-ordinator and the Director of Planning and Community Care [Board Paper No 04/67] asked the Board to:

- Endorse the conclusions of the Short Life Working Group.

- Charge the Chief Executive to establish a process to implement the recommendations.

- Receive an update within six months on the extent to which recommendations have been integrated into new organisational arrangements.

Ms Dhir and Ms Laughlin delivered a presentation to the Board outlining the report of the Short Life Working Group which was set up to examine critically current issues relating to corporate policy development and implementation. The Group had been chaired by Rani Dhir, non Executive Board Member with Councillor Danny Collins as Vice Chair. The key aim of the Group was to make a series of recommendations as to how NHS Greater Glasgow could become more efficient and effective in defining policy aimed at addressing different aspects of inequality and health and also in the implementation of such policy. Three phases of work were undertaken by the Group:

- Evidence was collected on current perceptions, attitudes and activity aimed at addressing inequalities within NHS Greater Glasgow, current national policy developments and good practice within other related organisations.

- This evidence was then used as the basis of a problem solving phase in order to bring forward recommendations.

- The Group considered how the new emerging organisational structure might impact on the Board's ability to address inequalities.

Ms Dhir explained that the Working Group had identified that inequalities and health had a number of dimensions that needed to be described and addressed. She described these and the nine key areas for health service intervention. Ms Laughlin presented the key findings and conclusions from the Group's work where the view had been endorsed that there was both a desire and a need to address the issues of inequalities in its complexity in a more systematic and accountable fashion in order to build a modern, contemporary service in Greater Glasgow.

This should have the effect of improving services for patients and health as well as maximising clinical effectiveness and partnership working. Achieving such a change required, as a first step, a more explicit statement on the role of NHS Greater Glasgow and its workforce, an agreement that there were implications for all services, settings and the entire workforce and meaningful action. Taking a mainstreaming approach required the integration of the different aspects of the inequalities agenda into policy, programmes and practice. Such an approach recognised the need to provide targeted services for specific population groups but more fundamentally established the principle and the means to ensure that a sensitivity to inequalities and the needs of a diverse population became the responsibility, in different ways, of everyone.

On the basis of the findings of the research phase and the problem solving process, the Short Life Working Group made eleven strategic recommendations. The new organisational arrangements designed to ensure delivery on Partnership for Care and Community Planning needed to take these strategic recommendations into account. As such, the Group also recommended that a detailed programme of action was agreed as soon as possible to deliver change.

In response to a question from a Member, Mr Divers commended the work done by the Group in such a short period of time and the pragmatic ways of taking action that had been suggested – these would be picked up with the Corporate Management Team.

Councillor Collins recorded his appreciation of the excellent work undertaken by the Group and encouraged the CMT to take on the challenges presented in the recommendations as a high priority.

DECIDED:

- That the conclusions of the Short Life Working Group be endorsed.
- That the Chief Executive be charged with establishing a process to implement the recommendations. **Chief Executive**
- That an update, within six months, on the extent to which recommendations had been integrated into the new organisational arrangements be received. **Director of Planning and Community Care**

137. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 04/68] asked the Board to note the progress on meeting waiting time targets.

Ms Renfrew referred to the number of patients waiting over six months at 30 November 2004 with availability status codes and without availability status codes.

Over six months waits reduced by 391 patients (23%) between October and November 2004. The number of patients waiting over six months with ASC codes reduced by 448 patients (5%) between October and November 2004.

NOTED

138. AIDS (CONTROL) ACT REPORT 2003/2004

A report of the Director of Public Health [Board Paper No 04/69] asked the Board to approve that the AIDS (Control) Act Report 2003/2004 be submitted to the Scottish Executive, published by the Board and widely distributed in accordance with the 1987 Act.

Dr Ahmed advised that during the year, there were 103 newly diagnosed cases of HIV infection among Greater Glasgow residents. Of these, 27 probably resulted from sexual intercourse between men, 57 from sexual intercourse between men and women, 2 from mother to child transmission, 14 from other or uncertain routes and 3 from drug injecting. Similar to last year, heterosexuals had the highest number of cases of any group – 55% of the total new cases reported.

Diagnosing HIV in the mother before birth enabled interventions that could prevent infection in the baby. NHS Greater Glasgow introduced routine antenatal HIV screening for pregnant women and this had been offered to all women receiving antenatal care in Glasgow since July 2003. Since screening began, 8 women had been identified as HIV positive.

There were 22 new cases of AIDS reported during the year. Clinicians reported a 35% increase in AIDS related events compared with 2002-2003 and this was almost exclusively due to patients presenting with an AIDS defining illness. There were 5 deaths during 2003-2004, which despite the increase in new AIDS cases reflected the efficacy of the drug treatment known as highly active anti-retroviral therapy (HAART).

Specialist services for people with HIV infection in Greater Glasgow were provided at the purpose built infectious diseases unit at Gartnavel Hospital. During 2003-2004, 523 patients were followed up, of whom around 80% were from Greater Glasgow. Compared with the previous year, the number of patients requiring admission had increased from 79 to 90, the number of bed nights had increased as had the average length of stay. This could be attributed to the overall rise in the cohort numbers, the greater numbers with AIDS defining symptoms and the increase in late presentations.

The cost of HIV related treatment was over £2m in 2003-2004. 69% of the patients currently attending for care were receiving anti-retroviral therapy. As the number of patients being treated was expected to continue to increase, the cost of drug treatment was likely to go on rising for the foreseeable future. The targeted preventive measures continued to focus on reducing transmission between men who had sex with men and drug injectors. Prevention of transmission due to heterosexual sex was addressed through the ongoing improvement in sexual health and family planning services in Glasgow.

In response to a question from a Member, Ms Renfrew who was Chair of the Sexual Health Group, advised that, although waiting for the issue of the national strategy, the Group was pursuing as vigorously as it could sexual health messages across NHS Greater Glasgow.

NOTED

139. QUARTERLY REPORTS ON COMPLAINTS : JULY – SEPTEMBER 2004

A report of the Head of Board Administration and Divisional Chief Executives [Board Paper No 04/70] asked the Board to note the quarterly reports on NHS complaints in Greater Glasgow for the period 1 July to 30 September 2004 and note an extract from the Information Service Division's (ISD) Annual Report entitled "NHScotland Complaints Statistics – Year Ending 31 March 2004".

Mr Hamilton referred to the improved performance at each Division from the last quarter against the national target. Mr Hamilton advised that the NHS Board awaited formal notification of the timescale of the introduction of the new NHS Complaints Procedure but that it appeared likely this would be 1 April 2005.

NOTED

140. MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 04/71] asked the Board to approve the following medical practitioners employed by the Primary Care Division of NHS Greater Glasgow to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984;

Dr Elspeth McCue
Dr Rona Gow
Dr Alison Gordon
Dr Rekha Hegde
Dr Alex Wootton
Dr Duncan Stewart
Dr Katherine McElroy
Dr Jennifer Murphy
Dr Luqman Khan
Dr Carol Bindon
Dr Olwyn Gallagher (previously approved in June when employed as a locum – now substantive)
Dr Blair Leslie (retrospective approval sought – Dr Leslie employed through an agency for one month)

DECIDED:

That the above-named medical practitioners be approved and authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984. **Director of Public Health**

141. AUDIT COMMITTEE MINUTES

The Minutes of the Audit Committee held on Tuesday 26 October 2004 [A(M)04/5] were noted.

NOTED

142. AREA CLINICAL FORUM NOTES

The Notes of a meeting of the Area Clinical Forum held on Tuesday 16 November 2004 [ACF(N)04/04] were noted.

NOTED

143. PHARMACY PRACTICES COMMITTEE MINUTES

The Minutes of the Pharmacy Practices Committee [Paper No 04/72] held on Tuesday 5 October 2004 were noted.

NOTED

144. INVOLVING PEOPLE COMMITTEE MINUTES

The Minutes of the Involving People Committee held on Wednesday 10 November 2004 [Board Paper No 04/73] were noted.

NOTED

145. NORTH GLASGOW UNIVERSITY HOSPITALS DIVISION MINUTES

The Minutes of the Divisional Management Team of North Glasgow University Hospitals Division held on Wednesday 24 November 2004 [Board Paper No 04/74] were noted.

NOTED

146. SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION MINUTES

The Minutes of the Divisional Management Team of South Glasgow University Hospitals Division held on Monday 11 October 2004 [Board Paper No 04/75] were noted.

NOTED

147. PRIMARY CARE DIVISION MINUTES

The Minutes of a meeting of the Divisional Management Team of the Primary Care Division held on Thursday 4 November 2004 [PCDMIN2004/03] were noted.

NOTED

148. YORKHILL DIVISION MINUTES

The Minutes of the Divisional Management Team of Yorkhill Division held on Friday 15 October 2004 [Board Paper No 04/76] were noted.

NOTED

149. MINUTES OF STANDING COMMITTEES

It was agreed that Minutes submitted to the NHS Board for noting which had not been formally approved by that Committee, should be appropriately labelled as "draft". **Head of Board Administration**

The meeting ended at 12.30 pm

GGNHSB(M)05/2
Minutes: 14 - 37

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 22 February 2005 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Dr F Angell
Mr J Bannon MBE
Mr J Best
Dr H Burns
Mr R Cleland
Councillor D Collins
Dr B Cowan
Ms R Crocket (to Minute 24)
Mr T Davison
Ms R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie (to start of Minute 20)
Dr R Groden
Councillor J Handibode
Mrs S Kuenssberg CBE (except Minute 23)
Mr G McLaughlin
Mrs J S Murray
Mrs R K Nijjar
Mr A O Robertson OBE
Mrs E Smith
Mrs A Stewart MBE
Councillor A White

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

Ms E Borland	..	Acting Director of Health Promotion
Mr J Cameron	..	Director of Human Resources, South Acute Division and Chair of the Car Parking Working Group (a Subgroup of the Transport and Access Group) (to Minute No 26)
Ms S Gordon	..	Secretariat Manager
Ms E Gregory	..	Communications Manager
Mr D Griffin	..	Acting Director of Finance
Mr J C Hamilton	..	Head of Board Administration
Ms S Laughlin	..	Women's Health Co-ordinator (for Minute 26)
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Planning and Community Care

B Y I N V I T A T I O N

Mrs P Bryson	..	Convener, Greater Glasgow Health Council
Ms G Leslie	..	Chair, Area Optometric Committee
Dr B West	..	Chair, Area Medical Committee

ACTION BY

14. APOLOGIES

Apologies for absence were intimated on behalf of Professor D Barlow, Mr R Calderwood, Councillor J Coleman, Mr P Hamilton, Ms A Paul, Mr C Fergusson (Chair, Area Pharmaceutical Committee), Mr J Cassidy (Chair, Area Nursing and Midwifery Committee) and Mr H Smith (Chair, Area Allied Health Professionals Committee).

ACTION BY

15. CHAIRMAN'S REPORT

The Chairman updated on the following:

(i) He had met with Professor David Kerr on 15 February 2005 to discuss his ongoing work in relation to planning the future of the NHS in Scotland and, in particular, the work being progressed by the National Planning Team. This had been a useful exchange and it was envisaged Professor Kerr's report would be issued by the end of May 2005.

(ii) He had chaired the Medical Additional Costs of Teaching (ACT) Workshop on 16 February 2005 at Stirling Management Centre which looked at the new evidence based formula for the allocation of funding to University Medical Schools and NHS Boards.

NOTED

16. CHIEF EXECUTIVE'S UPDATE

Mr Divers made reference to the following:

A meeting had been held on 17 February 2005 with colleagues at NHS Argyll and Clyde to discuss taking forward mutual areas of interest on a regional basis, in particular, acute services, mental health and Community Health Partnerships (CHPs). This meeting had formed one of a series of bi-monthly meetings that had been agreed would be held. It was considered that the Group had reached a point where it would be useful to broaden their coverage and remit and it was, therefore, agreed that colleagues from NHS Lanarkshire be invited to attend meetings in the future to take forward these areas on a tri-partite basis.

NOTED

17. MINUTES

On the motion of Dr B Cowan, seconded by Mr G McLaughlin, the Minutes of the meeting of the NHS Board held on Tuesday, 1 February 2005 [GGNHSB(M)05/1] were approved as an accurate record and signed by the Chairman.

18. MATTERS ARISING FROM THE MINUTES

The Matters Arising Rolling Action List was circulated and noted.

NOTED

19. IMPLEMENTING PARTNERSHIP FOR CARE – THE NEXT STEPS : OUTCOME OF CONSULTATION

A report of the Chief Executive [Board Paper No 05/06] asked the Board to:

- receive the comments submitted in response to the consultation paper "Implementing Partnership for Care – The Next Steps";

- confirm the Board level governance and committee arrangements set out in the paper;

- approve the creation of the structure proposed for acute services, comprising an Operating Division (including maternal and specialist children's hospital services), a Directorate for Rehabilitation and Older People's Services and an Acute Planning Team.

Mr Divers reminded the Board about the main focus of the consultation paper, which was moving away from the current Operating Divisions to a new structure for the planning and delivery of adult acute, maternity and specialist children's services as well as describing the proposals for the management of those services in terms of governance and corporate cohesion.

He restated the detailed core positions put to consultation and summarised the responses received to these proposals. The consultation process had included wide distribution of the paper and engagement with a number of key interests including Greater Glasgow Health Council, Local Authorities, Medical Staff Associations, the Local Medical Committee and senior managers. Eighty-one responses were received.

Mr Divers described the four main issues on which consultees' comments had been focussed including:

- Mental Health Partnership – a few responses had taken the opportunity to restate issues in relation to the mental health organisational arrangements which the Board had already approved. It was important to listen to those issues and ensure that they were addressed in concluding the detailed work setting out arrangements to develop the full organisational arrangements for mental health.

- Rehabilitation and Enablement – during the consultation, further discussions had taken place with the key clinical and managerial staff responsible for three component services namely, frail and mentally ill older people, physical disability and rehabilitation. Alongside the detailed design of the rest of the organisational arrangements, the Board would put forward revised proposals for rehabilitation and enablement services which addressed arising concerns while retaining the agreed principle that NHS Greater Glasgow should aim to manage these services in a way which brought them together into shared management arrangements.

- Adult Acute Services – the consultation proposed to link components for acute services, namely, a single Acute Division and a single Acute Planning Team. These proposals attracted relatively limited comment at a principle level. Where comments were made, they fell broadly into two groups:

    - the first comprised those who welcomed the move to a single, acute services operating structure as a logical progression from the current Divisional arrangements;

    - the second involved numerous detailed comments about aspects of the planning arrangements and structures within the Operating Division, which would be picked up as part of the detailed work underway to develop the management arrangements for this Division.

- Children Services – in reflecting on the consultation responses in relation to the Women and Children's Directorate, Mr Divers set out the strands of work being pursued in relation to community based children services. He commented that it was critical that, in the detail of the NHS organisational design, the Board followed through the logic of the integrated CHPs in relation to children's services and, in parallel with ongoing work with Local Authorities, the Child Health Strategy Group had been promoting the development of further thinking within the NHS about how local children's services could be organised and delivered. When that work was concluded, the migration of the present services into the new structures would be carefully managed as part of a detailed transition programme.

Mr Divers went on to describe a range of further issues arising from the consultation including:

- Transition Arrangements – a large number of responses raised concerns about implementation arrangements. Although more detailed migration arrangements remained to be made, it was the aim to conclude the final elements of work about the new organisational shape as quickly as possible, enabling the earliest possible appointments to the new structures. Thereafter, the Board would be in a position to put in place detailed migration plans which ensured that there were no changes to present organisational arrangements until the Board was clear that the new structure was able to take on a particular function. That rigour would be particularly important in relation to mental health services for adults and older people, specialist community children services, primary care services, health promotion, public health and planning responsibilities of the NHS Board. Equally, existing governance arrangements for finance, audit, risk management and clinical governance would not be changed until the replacements were fully developed and robust. Mr Divers reiterated this important message to NHS staff who would, naturally, be concerned about the significance of the change programme the reorganisation required.

- Disaggregation and Single System – the further development of headline propositions should give confidence that in meeting the Board's key objectives of delegation and evolution, it would retain a coherent and co-ordinated NHS Greater Glasgow.

- Scale of Change – in offering reassurance, Mr Divers stated that, in designing the detailed implementation arrangements, the Board would ensure a considered and sensibly paced migration to the new arrangements.

- Service and Function Change – it was important to recognise that although the intention was that new organisations were directed at changing the way services and responsibilities were delivered, those changes would take place over the medium and long term.

- Primary Care – it was not believed that a pan Glasgow primary care structure was a viable arrangement when the construct of CHPs included full devolution of primary care services, planning and health improvement. It was clear that there would need to be a systematic approach to pull together the work of individual CHPs and it was important to challenge the construct that the Acute Division could not, as a matter of principle, manage services traditionally managed by the Primary Care Division.

Mr Divers concluded by highlighting the wide range of important and useful issues, most of which could only properly be addressed when the Board had concluded the high level principles of organisation which would enable the detail of structures and implementation to be finalised and the complex transition to begin. It was important that the Board did not lose momentum at the first stage of its change programme – consultation on the overall shape of NHS Greater Glasgow. Approval of that shape would ensure that the publication of detailed structures for final discussion could take place within the next four weeks.

Sir John referred to the vastly different ways of working that the consultation proposals presented and, in parallel with this, the huge opportunity for NHS Greater Glasgow in managing the interface between the Board and its partners.

Mrs Kuenssberg emphasised the importance of looking at the positives that the proposals envisaged particularly in bringing together children's and women's services in one Directorate. She referred to the paradox for many Yorkhill staff who regarded themselves as currently working in a single system whereas the proposals placed them within an Adult Acute Division whilst simultaneously providing community services at CHP level. She was reassured, however, by the proposed transition arrangements and, in particular, that services would not be moved until alternatives were in place.

Mr Davison referred to the work of various subgroups that had been established to pull together the structures and propositions to ensure that service structures were aligned. He referred to this as a matrix style structure that connected all of the work within NHS Greater Glasgow. He was reassured that the direction of travel of integration was logical and sensible in planning for NHS Greater Glasgow's services.

Mrs Smith expressed the view that the Board should be comforted from the few responses received from NHS staff and Dr Angell advised that many staff had fed their comments through the professional advisory structure. Mrs Smith was also reassured by the transition arrangements and recognised that the management of this change had to be undertaken in an evolutionary partnership way.

In response to a question from Sir John, Mr McLaws referred to the communication effort which had taken place to advise staff of the proposals. This had included use of the Intranet, the Board website, staff briefings as well as notification to all those on the patient focus public involvement (PFPI) database and a range of coverage in local media and press releases.

Mr Robertson referred to what appeared to be a daunting task in progressing this change but advised that there was commitment to pursue the overall strategy to maximise opportunities and closer community working. He referred to the clinical governance arrangements, in particular, where NHS Greater Glasgow had nine CHPs working with six Local Authorities. It would be important to ensure a level of consistency across these to deliver levels of support and the transitional arrangements should give a greater degree of clarity and local stability to take this forward in a coherent fashion. He felt that a fourth recommendation should be added which would see a report coming to the March NHS Board meeting on the progress being made in key areas of the implementation process. This was agreed.

DECIDED:

- That the comments submitted in response to the consultation paper "Implementing Partnership for Care – The Next Steps" be received.

- That the Board level governance and committee arrangements set out in the paper be confirmed. **Chief Executive**

- That the creation of the structure proposed for Acute Services, comprising an Operating Division, including maternal and specialist children hospital services, a Directorate for rehabilitation and older people services and an acute planning team be approved. **Chief Executive**

- That the Chief Executive be charged with progressing the following key strands of work and reporting to the March NHS Board meeting on the implementation plan for: **Chief Executive**

  - Primary Care
  - Future arrangements for Public Health, Health Promotion and Planning
  - Acute Operating Division
  - CHPs
  - Clinical governance, risk management and other governance
  - Child Health Strategy Group

20. COMMUNITY HEALTH PARTNERSHIPS :

- **SCHEME OF ESTABLISHMENT IN WEST DUNBARTONSHIRE COUNCIL**
- **UPDATE ON THE PROGRESS**

A report of the Director of Planning and Community Care [Board Paper No 05/07] asked the Board to:

- approve the proposed Scheme of Establishment for a Community Health Partnership in West Dunbartonshire Council;

- note progress on establishing Community Health Partnerships with:

  - South Lanarkshire Council
  - East Renfrewshire Council
  - Glasgow City Council.

Mr Goudie expressed his concern that the trade unions and staff side officials were in official dispute with the NHS Board over the Schemes of Establishment for Community Health Partnerships and the Board had been asked not to introduce any further Schemes of Establishment until this had been resolved. As such, he asked that the Board did not consider this paper until a mutual resolution had been reached.

Mr Divers advised that ongoing work and dialogue would take place with the trade unions and the Area Partnership Forum to move this forward to a resolution but that, in the meantime, it was reasonable for the Board to consider this paper. Mr Reid advised that the current dispute had been discussed recently at the Staff Governance Committee and he was expecting to see ongoing and intensive discussions taking place in the near future to resolve the dispute. Ms Renfrew confirmed that the NHS Board would seek further discussions with the Area Partnership Forum to reach a form of words in relation to staff partnership and governance prior to submission to the Scottish Executive Health Department. Mr Goudie reiterated that this was an official dispute and he could take no part in any further discussions if the Board decided to consider this paper. Mr Goudie left the meeting.

Ms Renfrew led the Board through the draft Scheme of Establishment for a Community Health Partnership (CHP) covering the West Dunbartonshire area. The proposed CHP brought into a single authority wide structure the responsibilities for local health services and health improvement of the appropriate area of Argyll and Clyde and Greater Glasgow NHS Boards.

West Dunbartonshire Council did not wish to pursue the Board's preferred model of an integrated CHP and, therefore, the Scheme of Establishment covered only NHS responsibility. The Scheme of Establishment, subject to approval by Argyll and Clyde NHS Board in early March, was a significant step forward in bringing together services to a single population and, in achieving co-terminusity with the Council area, provided a platform to strengthen and extend joint working.

In response to a question from Dr Groden in relation to the membership of the CHP Board, Ms Renfrew confirmed that it would be chaired by a Board Non Executive Member.

Mr Davison was of the view that the Board should take advantage of the two defined models of CHPs and, at a later date, evaluate these two models to compare and contrast their impact within local communities.

Councillor White expressed the view that much time had been taken in forming the boundaries of CHPs in NHS Greater Glasgow but little time on the actual formation of the Schemes of Establishment. Over and above this point, he was confident that the paper reflected fairly the discussions with West Dunbartonshire Council.

Mr McLaughlin referred back to the point made by Mr Goudie and was reassured by Mr Reid that the issues around staff governance and the composition and remit of partnership forums within CHPs would be fully discussed with the Area Partnership Forum in an attempt to find a satisfactory resolution to the outstanding areas of concern. On this point, Mr Divers confirmed that further dialogue would take place with Mr Goudie to try and agree a form of words to be added to the report to resolve this matter prior to it being submitted to the Scottish Executive Health Department.

Chief Executive

In terms of progress with other Local Authorities, Ms Renfrew updated on the following:

- East Dunbartonshire Council – the Council and the Board had already approved a Scheme of Establishment for a health and social care partnership.

- Glasgow City Council – the Council had endorsed a joint approach to the development of CHPs and instructed the Chief Executive and the Director of Social Work Services to lead negotiations with NHS Greater Glasgow to establish those joint CHPs. Discussions were underway to develop a Scheme of Establishment for consideration by the Council and the NHS Board during March.

- South Lanarkshire Council – the previous update to the Board noted that South Lanarkshire Council did not wish to pursue an integrated model CHP and that Lanarkshire NHS Board did not wish to establish a cross-boundary CHP including the population of Rutherglen and Cambuslang. This raised the issue about the viability of a health only CHP for a relatively small population which the Board undertook to discuss further with the Council. The outcome of those further discussions was an agreement to engage with Lanarkshire NHS Board to discuss their boundary proposals. That further engagement had led to a detailed review between the three parties of potential boundary options. The Board would be kept informed of progress.

- East Renfrewshire Council – the Council was considering its position on the integrated model of CHPs over the next three weeks. The Council's conclusions would then inform the development of a Scheme of Establishment for the Board's consideration.

DECIDED:

- That the proposed Scheme of Establishment for a Community Health Partnership in West Dunbartonshire Council be approved subject to further discussions with the Area Partnership Forum on the outstanding issues highlighted above and prior to its submission to the Scottish Executive Health Department. **Director of Planning and Community Care**

- That progress on establishing Community Health Partnerships with South Lanarkshire Council, East Renfrewshire Council and Glasgow City Council be noted. **Director of Planning and Community Care**

21. NHS GREATER GLASGOW NO-SMOKING POLICY

A report of the Acting Director of Health Promotion [Board Paper No 05/08] asked the Board to approve the draft No-smoking Policy for consultation with staff and public.

Ms Borland described the primary focus of the policy which was to protect staff, visitors and patients from the harmful effects of environmental tobacco smoke. It also included support for staff and patients to stop smoking and recognised the contribution the policy could make to smoking prevention and the reduction of smoking rates in the wider community.

Currently each part of NHS Greater Glasgow had its own no-smoking policy and, in the main, these policies were similar and promoted a situation where smoking was allowed only in designated smoking areas and smoking rooms (available in some hospitals). In practice, however, the policies were less well defined resulting in ambiguity regarding where and when staff and public could smoke. Over time, the reliance on the discretion of local management regarding what was appropriate had resulted in a lack of consistency that undermined the enforcement of the policies. There was a need, therefore, for a single, unified policy for the whole of NHS Greater Glasgow which would have the support of staff and public (smokers and non smokers) and which could be implemented effectively.

The Scottish Executive proposed ban on smoking in enclosed public places would provide a strong legislative framework to support the policy. It would be mid 2006, however, at the earliest before this ban was in place and the introduction of NHS Greater Glasgow's own policy in the meantime would ensure that NHS Greater Glasgow was prepared to meet the new legislative requirements.

Ms Borland led the Board through the key provisions in the policy and explained that while the detail of the Scottish ban on smoking in public places had yet to be worked through, it was likely that it would be similar to that operating in the Republic of Ireland.

She explained that the successful implementation of the policy would depend upon unambiguous and visible commitments from the Board, management and staff throughout the whole organisation noting that successful implementation would also require to be adequately resourced.

Ms Borland acknowledged that it was difficult to achieve the right balance between giving a clear message that NHS Greater Glasgow was anti-smoking and gaining support of all (staff and public, smokers and non-smokers) on whose compliance it ultimately relied. The consultation would provide the opportunity to determine whether the draft policy had achieved this. It was the intention to consult widely with staff and public using a range of communication channels including Staff News, Health News, intranet, NHSGG website, staff partnership structures and the Involving People network. The consultation would be carried out during the period March to June 2005.

Dr Burns emphasised that smoking was socially unacceptable and that the draft no-smoking policy struck a good balance and provided a clear sense of travel in reiterating that NHS Greater Glasgow did not support smoking on NHS premises. In progressing this, he accepted that staff and patients would be supported to give up smoking.

In response to a question from Dr Groden, Ms Borland explained that one of the exemption categories which referred to psychiatric departments referred to long-stay patients only.

Mrs Murray sought clarity that staff would be supported when dealing with visitors to health care premises who smoked and were trained in how to manage implementation of the policy in this respect.

Councillor Handibode asked how implementation of this policy could be policed. Dr Burns was hopeful that staff and patients would respect the policy and all groups (staff, patients and visitors) would be offered cessation services. He reiterated that smoking killed 3,000 people in Glasgow every year and was the single biggest avoidable problem that existed. He did not underestimate the challenge that lay ahead but thought the policy provided a platform to progress this in a measured way.

In issuing the policy for consultation, Ms Dhir suggested the Board define what it regarded as being a building, an area and grounds particularly as sites across NHS Greater Glasgow varied greatly. Ms Borland agreed to clarify this point prior to the consultation being issued. **Acting Director of Health Promotion**

Councillor Collins referred to the well supported no-smoking policy that had operated in East Renfrewshire Council. He asked that in issuing the consultation response questionnaire, a box be added asking if the respondee was a smoker or non-smoker as this may assist in the analysis of responses. **Acting Director of Health Promotion**

DECIDED:

The NHS Greater Glasgow no-smoking policy be amended to reflect Members' comments and thereafter be approved and issued for consultation with staff and public with a report back to the NHS Board in August 2005. **Acting Director of Health Promotion**

22. WEST SECTOR REPROVISION OF MENTAL HEALTH SERVICES – FULL BUSINESS CASE

A report of the Acting Chief Executive, Primary Care Division [Board Paper No 05/9] asked the Board to consider the Full Business Case for Mental Health West Sector Inpatient Reprovision and approve the submission of the Full Business Case to the Scottish Executive.

Ms Crocket advised that the purpose of the paper was to submit a Full Business Case for the reprovision of the main inpatient services currently located on the Gartnavel Royal Hospital site to a new build facility to be constructed on an agreed foot-print designated within the Gartnavel master plan. This would allow for replacement of old and unsuitable accommodation currently located on that site.

Ms Crocket summarised the Full Business Case submission and referred, in particular, to the key milestones and timetable to the financial close and delivery of services which was:

- Primary Care Division FBC approval — 3 February 2005
- NHS Greater Glasgow Board approval for FBC — 22 February 2005
- Scottish Executive approval of FBC — 14 March 2005
- Financial close — 31 March 2005
- Commence construction — July 2005
- Complete construction — June 2007
- Service commencement — August 2007

Mr Robertson encouraged approval of this Full Business Case to get the wheels in motion for construction to commence. Councillor Duncan echoed this view.

DECIDED:

- That the Full Business Case for Mental Health West Sector Inpatient Reprovision be approved. **Acting Chief Executive, PCD**

- That submission of the Full Business Case to the Scottish Executive be approved. **Acting Chief Executive, PCD**

23. LOCAL FORENSIC PSYCHIATRIC UNIT CONTRACT FOR PROVISION OF UNIT

Mrs Kuenssberg declared an interest in this item and, therefore, left the meeting during consideration of this item.

A report of the Acting Chief Executive, Primary Care Division [Board Paper No 05/10] was submitted on the provision of the Local Forensic Psychiatric Unit.

Ms Crocket invited Mr Griffin to update on the current status of the project. Mr Griffin explained that the project was being taken forward through Public/Private Partnership (PPP) and that its purpose was to create a local forensic psychiatric facility which would provide services as discussed and outlined in the NHS Board Minute of the meeting of 20 April 2004. Copies of the principal documents to be entered into by the Board pursuant to the project ("Project Documents" listed below) were available to Members for their consideration. Mr Griffin explained that the project documents were not yet in their final form and would be subject to amendments as advised necessary by the Board's external advisers. Any such amendments would be consistent with the general agreed principles of the project documents exhibited at the meeting. He explained that the project was moving towards financial close.

The "Project Documents" referred to were as follows:

(i) Project agreement between the Board and Stobhill Healthcare Facilities Limited.

(ii) Funders direct agreement between the Board, Dexia Public Finance Bank and Stobhill Healthcare Facilities Limited.

(iii) Construction direct agreement between the Board and Balfour Beattie Construction Limited.

(iv) Services direct agreement between the Board and Parsons Brinckerhoff Limited

(v) Independent tester contract amongst the Board, Stobhill Healthcare Facilities Limited, Capita Simons, Dexia Public Finance Bank and Balfour Beattie Construction Limited.

DECIDED:

- That approval for the Board to enter into a contract, based on the project documents and additional documentation required in connection with the project as advised by the Board's external advisers be given. **Acting Chief Executive, PCD**

- That any two from the Chief Executive, the Acting Director of Finance/Director of Finance, Primary Care Division, the Director of Planning and Community Care and the Acting Chief Executive, Primary Care Division, be authorised to consider and agree any such amendments after the date of the meeting, including agreement of the final pricing amendments to the project documents as advised by the Board's external advisers provided any such amendment was consistent with the general agreed principles of the project documents exhibited at the meeting. **Acting Chief Executive, PCD**

- That any two/three from the Chief Executive, the Director of Finance/Director of Finance, Primary Care Division, the Director of Planning and Community Care and the Acting Chief Executive, Primary Care Division, be authorised to sign and deliver, on behalf of the Board, the project documents with such amendments to the project documents as advised by the Board's external advisers and any additional documentation required in connection with the project as advised by the Board's external advisers (provided any such amendments were consistent with the general agreed principles of the project documents exhibited at the meeting). **Acting Chief Executive, PCD**

- That the Acting Director of Finance/Director of Finance, Primary Care Division be authorised as the named individual on behalf of Greater Glasgow NHS Board for the purpose of the insurance proceeds account to be opened in terms of the project agreement. **Director of Finance, PCD**

- That the Chairman produce a certified copy of the Minute of the proceedings of the meeting as verification that approval had been granted. **Chairman**

Mrs Kuenssberg returned to the meeting

24. REVIEW OF ASSUMPTIONS UNDERPINNING JUNE 2002 DECISIONS ON ACCIDENT AND EMERGENCY SERVICES

A report of the Director of Planning and Community Care [Board Paper No 05/11] asked the Board to consider the outcome of the review of assumptions underpinning June 2002 decisions on Accident and Emergency (A & E) Services and confirm that those assumptions which underpinned the two site A & E model approved in the Acute Services Review remained valid. The review had been carried out to meet a requirement set down in September 2002 by the Minister for Health and Community Care that the Board would review these assumptions in two years' time.

Ms Renfrew outlined the three stage process undertaken to meet the commitment to retest the assumptions which underpinned the two site A & E model included in the Acute Services Review as follows:

- Stage 1 – a detailed paper restating the original analysis which underpinned the decisions and the programme of work which had taken place since June 2002 was circulated to a wide range of key interests inviting their feedback.

- Stage 2 – a major workshop was held in October 2004 designed to enable direct debate with key interests.

- Stage 3 – a report back to the Board – the purpose of this paper to report the outcome of the above processes.

Ms Renfrew outlined and addressed the issues the review process had raised. She described the three different types of response that the engagement had led to as follows:

- Some interests simply restating positions taken in the earlier consultation.

- A number of stakeholders clearly had limited knowledge of the proposals and the significant debate and consultation around them over a two year period. They, therefore, had a legitimate desire to see a rerun of the full consultation process which this relatively boundaried process could not meet.

- Issues and discussion which did focus on the key assumptions.

She summarised the points emerging from this last group of responses against the original key assumptions which were:

- Patients would be streamed into the appropriate services, not all routed through a single A & E entry point.

- Localised minor injuries services would treat substantial numbers of patients and timely access for seriously ill patients would not be compromised.

- The Board set out the volume of patients who would be treated in each service.

- Significant changes needed to be made to arrangements for dealing with acute admissions and the Board needed to plan the right number of beds.

She led the Board through an updated position of each of these assumptions. Over and above this, the review had highlighted three further noteworthy areas as follows:

- Argyll and Clyde NHS Board's clinical strategy
- Waiting times for treatment and admission
- Major incident responses

In concluding, Ms Renfrew confirmed that the detailed emergency review process had not highlighted any new issues or challenges to the key assumptions which underpinned the two site A & E proposal. It did re-emphasise, however, the importance of substantial and effective communication on a number of issues which continued to cause concerns among key interest groups. These particularly related to the durability of the final arrangements for beds, ambulances and other infrastructure when NHS Greater Glasgow moved to two sites.

Councillor White encouraged the Board not to commit itself to two A & E sites but to keep the matter under review as a lot of changes had taken place since the original June 2002 decisions particularly in relation to regional planning. He advised that he had met Professor David Kerr who was leading work in looking at national planning across NHS Scotland and who was due to produce a report late in May. Councillor White was of the view that a decision should not be reached until Professor Kerr's report was published to ensure that the Board could take account of any issues raised in his report.

Ms Renfrew agreed that when this report was published the Board would wish to consider its recommendations but was not of the view that this should delay a decision being made today. She referred, in particular, to the evidence base produced in the paper which was on patient flows and not NHS Board boundaries. She referred to the A & E closure at the Vale of Leven (within Argyll and Clyde NHS Board area) which had not affected patient flows to NHS Greater Glasgow.

Mr Best referred to the successful shift in pattern of children previously presenting to an adult acute hospitals – now almost 98% of ambulance journeys for children attended Yorkhill A & E.

Mr Divers reminded Members that the three stage process had been approved by the Board of the review. He confirmed that the Board had undertaken the work required by the Minister for Health and Community Care. As such, it was appropriate thus, to report to the Minister the outcome of the three stage review. Any recommendations contained within Professor Kerr's report which had implications for the Board's strategies would be looked at with the appropriate planning partners at that time. He reiterated that as and when fresh issues arose, the Board would certainly look at these.

DECIDED:

- That the outcome of the review of assumptions underpinning June 2002 decisions on A & E services be considered. **Director of Planning and Community Care**
- That those assumptions which underpinned the two A & E sites model (approved in the Acute Services Review) be confirmed and remain valid. **Director of Planning and Community Care**

25. NHS GG DRAFT CAR PARKING POLICY

A report of the Chief Executive, Yorkhill Division [Board Paper No 05/12] asked the Board to consider the outcome of the consultation on the draft Car Parking Policy.

Mr Best welcomed Mr Cameron to the meeting as Chair of the Car Parking Working Group (a subgroup of the Transport and Access Group). Mr Cameron advised that the proposed policy was a framework document which set out principles which should underpin the introduction of car park charging arrangements on a fair and consistent basis pan-Glasgow, and it sought to deal with the tension between the need to ensure staff could get to their workplace while enabling patients and their visitors, many of whom were elderly and disabled, to have reasonable access to NHS Greater Glasgow's hospitals.

He described the consultation process which concluded in November 2004. An independent panel evaluated over 200 responses and submissions received.

The feedback particularly highlighted some anxiety as to the practicalities of implementation particularly as it applied to staff working cross-sites, disabled access and early and late shift workers. The aim would be, if the policy was approved, to establish a "Glasgow permit office" to ensure the consistent and effective management of car parking pan-Glasgow.

The need for better public transport links was also raised as a significant issue and the feedback from the consultation process would be directed to the Board's Transport and Access Group who were currently working with Strathclyde Passenger Transport, Glasgow City Council and public transport providers to enhance the provision of services to Glasgow hospital sites.

In response to a question, Mr Cameron confirmed that the implementation group set up to establish an action plan to implement the Car Parking Policy would include patients/visitors representation and from the staff side of the Area Partnership Forum.

Ms Dhir encouraged the policy to be clear in terms of its definition of staff, visitors, patients and carers to ensure clarity and fairness across the principles.

Mr Davison reported that the North Division had already utilised these draft principles when reviewing car parking provision at Glasgow Royal Infirmary (GRI). In reviewing the timetable for implementation, he reminded the NHS Board that the new car park complex at GRI was due to be completed this summer and encouraged the implementation group to resolve the permit issue by late Spring/early Summer 2005 to facilitate implementation on the GRI site earlier.

In response to a question from Mrs Nijjar, Mr Cameron advised that the implementation group would be flexible in its considerations to cover various circumstances such as a visitor who attends the hospital several times a day.

DECIDED:

- That the outcome of formal discussion and engagement with NHS Greater Glasgow patients, public and staff be noted. **Chief Executive, Yorkhill Division**
- That the Car Parking Policy document be approved. **Chief Executive, Yorkhill Division**
- That the Chief Executive be delegated to set up a partnership based implementation group which will be required to establish an action plan to implement the Car Parking Policy across the designated sites over the period to 1 April 2006 on a cost neutral basis. **Chief Executive**

26. BEING OUTSIDE : CONSTRUCTING A RESPONSE TO STREET PROSTITUTION – REPORT OF THE EXPERT GROUP ON PROSTITUTION IN SCOTLAND - RESPONSE TO CONSULTATION

A report of the Director of Planning and Community Care, Women's Health Co-ordinator and Senior Health Promotion Officer Sexual Health [Board Paper No 05/13] asked the Board to welcome the Being Outside report as a response to addressing the important issue of street prostitution and agree that the concerns detailed in the paper were submitted as a response to the consultation.

Ms Renfrew introduced Ms Laughlin who was in attendance to present the report.

Ms Laughlin referred to prostitution being a major issue for NHS Greater Glasgow as the health consequences of involvement in prostitution were significant. The magnitude and complexity of health problems exhibited by women involved in prostitution meant that they were likely to use a range of health services in both primary and secondary care as well as to seek support from voluntary sector organisations. There was a need, therefore, for health care providers to be sensitive to the health problems that women presented with and to assess their health problems sensitively.

The view in Glasgow was that mainstream and specialist NHS services needed to be available to all women involved in prostitution. There was also the view that services had a responsibility to make themselves as accessible as possible. NHS Greater Glasgow had developed and funded specialist services such as Base 75, the Supporting Women Abused Through Prostitute Project (SWAPP), the Centre for Women's Health and Local Addiction Project. All of these services were known to be used by women who were involved in prostitution.

Ms Laughlin summarised the report from the Expert Group which had been set up in August 2003 to carry out a comprehensive report, on behalf of the Scottish Executive, of the wide ranging issues surrounding prostitution in Scotland. "Being Outside : Constructing a Response to Street Prostitution (2004)" was the first product for consultation from this Expert Group and it made recommendations in four key areas as follows:

- Preventing involvement
- Early intervention
- Reducing harm
- Exiting

These elicited a number of common challenges regarded as defining the strategic objectives which any strategy to respond to the problem must fulfil. Such objectives contained dilemmas to which policy and practice must also respond and those had dominated the considerations of the Group.

Ms Laughlin identified the proposed way forward for the Group and summarised the NHS Board's proposed response highlighting that whilst the Expert Group report was welcome in that it provided a greater focus on this important issue, a number of the detailed recommendations were not adequate to seriously tackle such a significant public policy challenge.

Mrs Smith echoed the view of Ms Laughlin in that the report had not addressed some important issues. She referred, in particular, to the ongoing work and lessons learned in studies undertaken in Sweden. Similarly she highlighted the Social Inclusion Partnership (SIP) and 218 Project, both of which worked in the field of prostitution and commended their work.

In response to a question from Mrs Stewart, Ms Renfrew confirmed that, at CHP level, an interest would be taken in tackling inequalities and prostitution was one example of this. Projects such as 218 and Base 75 would continue to exist as they were and would not, however, be fragmented over the nine CHPs. Dr Burns added that CHPs may further play a role in preventative measures of prostitution.

Mr McLaughlin suggested that as well as the academic points to be included in the NHS Board's response, emphasis should be added to the Board's own experiences in dealing with prostitution and the successes of projects such as 218 and Base 75.

DECIDED:

- That the Being Outside report as a response to address the important issue of street prostitution be welcomed. **Director of Planning and Community Care**
- That the concerns detailed in the paper be submitted as a response to the consultation. **Director of Planning and Community Care**

27. PATIENTS' PRIVATE FUNDS STATEMENT OF ACCOUNTS FOR 2003/04

A report of the Acting Director of Finance [Board Paper 05/14] was submitted on the Patients' Private Funds Accounts for 2003/2004.

Mr Griffin explained that following the dissolution of Trusts on 31 March 2004, the Board was responsible for signing off the Patients' Private Funds Accounts for the year 31 March 2004.

The Divisions held the private funds of residents and patients who had no ready alternative to safe keeping and management of the funds. Each of the hospitals maintained individual patient records of funds. Any funds not available for immediate use were invested in interest bearing deposit accounts. The interest generated by those accounts was distributed across patients' accounts based on balances held.

DECIDED:

- That the 2003/04 Patients' Private Funds Statement of Accounts for the former Trusts, namely, North Glasgow University Hospitals NHS Trust, South Glasgow University Hospitals NHS Trust and Greater Glasgow Primary Care NHS Trust be adopted and approved. **Acting Director of Finance**

- That the Acting Director of Finance and the Chief Executive be authorised to sign the consolidated Trusts Patients' Private Funds Annual Accounts Statement and the Chairman and the Acting Director of Finance be authorised to sign the Statement NHS Trusts Management Team Responsibilities **Acting Director of Finance**

28. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 05/15] asked the Board to note progress made in meeting national waiting times targets.

NHS Greater Glasgow had agreed to two main waiting time milestones (numbers waiting beyond 26 weeks for outpatients, inpatients/day cases) in 2004/05 – for December 2004 and for March 2005. These milestones were agreed as part of the 2004 Accountability Review process. Ms Renfrew reported that NHS Greater Glasgow had achieved the December 2004 milestone and, at this point, plans were in place and on track to ensure delivery of the March 2005 milestone of a maximum of 12,000 outpatients and 700 inpatients/day cases waiting longer than 26 weeks.

No milestones had been agreed for the period from April to December 2005 inclusive. It was important, however, that the Board continued to phase the reduction in waiting times so that both the December 2005 target was met and was delivered and sustained thereafter. By December 2005, NHS Greater Glasgow would have no patient waiting beyond 6 months for an outpatient appointment or for the subsequent inpatient/day case treatment that may be required.

Sir John commended all staff involved in meeting these milestones and had asked Mr McLaws to convey this in the next edition of the Staff News. **Director of Corporate Communications**

In response to a question from Dr Angell, Mr Divers advised that targets for referrals from General Dental Practitioners and Optometric referrals were currently being reviewed.

In response to a question from Dr West regarding referral for plastic surgery, Mr Divers confirmed that work was being taken forward at two levels (regionally and nationally) to ensure consistency in patterns of referral for plastic surgery and their appropriateness.

NOTED

29. CONTINUATION OF THE LHCC PROFESSIONAL ADVISORY COMMITTEE

A report of the Chief Executive [Board Paper No 05/16] asked the Board to approve the continuation of the Local Health Care Co-operative (LHCC) Professional Advisory Committee pending the full establishment of Community Health Partnerships and their related advisory arrangements.

Mr Divers stated that the LHCC Professional Advisory Committee brought together representatives from all of the professional groups within primary care. It had an important role in developing policy for the LHCCs and, through its Chair, in contributing to thinking at the NHS Board. As such, it was proposed that, until revised organisational arrangements were in place, the LHCC Professional Advisory Committee should continue as at present. This gave a clear message to primary care contractors and staff that the NHS Board continued to value their views and advice as NHS Greater Glasgow moved to the detailed discussion beyond the outline Schemes of Establishment for Community Health Partnerships.

DECIDED:

That the continuation of the LHCC Professional Advisory Committee (pending the full establishment of Community Health Partnerships and their related advisory arrangements) be approved. **Chief Executive**

30. FUTURE ARRANGEMENTS FOR SERVICE REDESIGN AND IMPROVEMENT

A report of the Chair, Service Redesign Committee and Director of Planning and Community Care [Board Paper No 05/17] asked the Board to approve the paper as a basis for wider discussion about future arrangements for service redesign and improvement.

Mr McLaughlin reported that the Board's Service Redesign Committee had been in place for one year and that it had decided that its first anniversary, coupled with impending changes to wider NHS organisational arrangements, meant it should review its progress. He led the Board through the conclusions of that review in the context that, while the improvement of NHS services must remain a key priority for the Board, a separate subcommittee with that focus may not be the best vehicle to deliver added value. The move to a different NHS organisation could create other opportunities to embed improvement throughout the organisation and within much more systematic performance arrangements.

Ms Renfrew advised that Service Redesign Committees were required to be created by the Partnership for Care White Paper and NHS Greater Glasgow's was established at the end of 2003 with the Board carefully considering a role and remit for the Committee within the wider context of NHS Greater Glasgow. She explained that the Service Redesign Committee had had the benefit of reviewing the remit and constitution of other NHS Board Service Redesign Committees within NHS Scotland and explained the wide array of differences that existed.

Dr Cowan commented on the huge amount of service design work ongoing in NHS Greater Glasgow and the links that existed from these to the Acute Services Review and Managed Clinical Networks.

Mr McLaughlin had discussed with Mr Robertson (Chair, Performance Review Group) whether there were any linkages in the areas of Service Redesign and Performance Review. They had agreed that this may be something that could be explored further and Sir John echoed these views in terms of the impact of service redesign being audited and accountable.

Mrs Kuenssberg encouraged the Board to recognise and celebrate successful service redesign initiatives by offering scholarships and prizes.

DECIDED:

That the attached paper form a basis for wider discussion about future arrangements for service redesign and improvement be approved. **Director of Planning and Community Care**

31. REMIT OF PERFORMANCE REVIEW GROUP AND CHANGES TO DECISIONS RESERVED FOR THE BOARD

A report of the Head of Board Administration [Board Paper No 05/18] asked the Board to endorse the revised remit of the Performance Review Group and subsequent changes to decisions reserved for the NHS Board.

Mr Hamilton explained that it had been agreed at the August 2004 NHS Board that all Committees review their remit and composition and, thereafter, make any recommendations to the NHS Board should any change be proposed. The Performance Review Group was established as a Standing Committee of the NHS Board in August 2003. He referred to the original remit of this group and the amendments made to strengthen its remit allowing it to take greater delegated authority from the NHS Board.

Ms Dhir sought clarification around the timing of this request when the totality of the NHS Greater Glasgow (and, therefore, its supporting Committee structure) had yet to be finalised. Mr Divers replied by confirming that, in the interim, the Audit Committee had agreed to the revisions, whilst acknowledging that the Group's composition would need to be reviewed shortly in light of the forthcoming changes to the organisational arrangements for NHS Greater Glasgow and there was a need for the Group to continue its work as proposed in the redrafted report.

DECIDED:

That the revised remit of the Performance Review Group and subsequent changes to decisions reserved for the NHS Board be endorsed. **Head of Board Administration**

32. PERFORMANCE REVIEW GROUP MINUTES

The Minutes of the Performance Review Group meetings held on 30 November 2004 [PRG(M)04/7] and 18 January 2005 [PRG(M)05/1] were noted.

NOTED

33. AUDIT COMMITTEE MINUTES

The Minutes of the Audit Committee meeting held on 25 January 2005 [A(M)05/1] were noted.

NOTED

34. PRIMARY CARE DIVISION MANAGEMENT TEAM MINUTES

The Minutes of the Primary Care Division Management Team meetings held on 13 January 2005 [PCDMIN 2005/01] and 2 February 2005 [PCDMIN 2005/02] were noted.

NOTED

35. SOUTH GLASGOW UNIVERSITY HOSPITALS DIVISION MINUTES

The Minutes of the South Glasgow University Hospitals Division meeting held on 8 December 2004 [Board Paper No 05/19] were noted.

NOTED

36. INVOLVING PEOPLE COMMITTEE MINUTES

The Minutes of the Involving People Committee meeting held on 11 January 2005 [Board Paper No 05/20] were noted.

NOTED

37. PHARMACY PRACTICE COMMITTEE MINUTES

The Minutes of the Pharmacy Practice Committee meeting held on 1 February 2005 [Board Paper No 05/21] were noted.

NOTED

The meeting ended at 12.40 pm

GGNHSB(M)05/7
Minutes: 107 - 123

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 20 September 2005 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Best
Mr R Calderwood
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B Cowan
Ms R Crocket
Mr T A Divers OBE
Councillor R Duncan
Mr W Goudie
Dr R Groden
Mr P Hamilton
Councillor J Handibode
Mrs S Kuenssberg CBE
Ms G Leslie
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Mr A Robertson OBE (to Minute 114)
Mrs E Smith
Mrs A Stewart MBE

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

Ms S Bustillo	..	Communications Manager
Ms E Borland	..	Acting Director of Health Promotion
Ms S Gordon	..	Secretariat Manager
Ms J Grant	..	Acting Chief Executive, North Acute Division
Mr D Griffin	..	Acting Director of Finance
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Planning and Community Care
Mr D Thomson	..	Associate Director of Finance, PCD (for Minute No 115)
Mr G McMenemy	..	Representative from McClure Naismith (for Minute No 115)

ACTION BY

107. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon, Professor D Barlow, Ms R Dhir, Ms A Paul, Councillor A White, Mr D Thomson (Chair, Area Pharmaceutical Committee), Dr C R Bell (Joint Chair, Area Dental Committee), Mr P Bennington (Joint Chair, Area Dental Committee), Ms L Love (Chair, Area Nursing and Midwifery Committee), Mr H Smith (Chair, Area Allied Health Professionals Committee) and Mr A J McMahon (Chair, Area Medical Committee).

ACTION BY

108. CHAIRMAN'S REPORT

(i) Sir John referred to the "Our Health 3" event held on 31 August 2005 at the Royal Concert Hall. Mr P Hamilton, Chair, Involving People Committee advised that the event had been very successful with around 250/300 people in attendance. Positive feedback had been received and a formal report was expected to be sent to all delegates in around three weeks time along with a copy of NHS Greater Glasgow's DVD entitled "Modernising Hospital Services". Mr Hamilton thanked all NHS Greater Glasgow staff involved in planning the event and those in attendance who helped it run smoothly. He looked forward to "Our Health 4" being arranged. Councillor Collins thanked Mr Hamilton for his contribution on the day and commended all the presentations which had been excellent and very informative.

Sir John also alluded to the NHS Board's Annual Review with the Minister for Health and Community Care which had been held in the afternoon of 31 August 2005. Following a private session with the Area Partnership Forum and the Area Clinical Forum, the Minister held a public session with senior Board officers which had also been well attended.

NOTED

109. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers expected to receive the formal letter from the Minister for Health and Community Care following the NHS Board's Annual Review in time for the October Board meeting and this would be included on the agenda. The receipt of this letter would also allow the NHS Board to sign off its Corporate Objectives for 2005/06.

(ii) The series of meetings between NHS Greater Glasgow, NHS Argyll and Clyde and NHS Highland continued to prepare for the dissolution and integration of responsibilities of NHS Argyll and Clyde. A detailed project plan had been prepared to take forward these responsibilities and engagement events would be scheduled for late October/early November with key stakeholders on how this would be progressed. The Minister for Health and Community Care's consultation on NHS Argyll and Clyde's boundaries was scheduled to end on Friday 4 November 2005.

(iii) The Calder Advisory Group had had its first meeting on 2 September 2005 and Mr Divers, Dr Cowan and Ms Renfrew had attended the public session orientating the Group on the strategic work of NHS Greater Glasgow's acute services and, in particular, maternity and children's services. The Group had given its agreement for the Board to proceed with the option appraisal process and public advertisements had been placed notifying of the first event which was scheduled for 3 October 2005.

NOTED

110. MINUTES

On the motion of Mrs S Kuenssberg, seconded by Mrs A Stewart, the Minutes of the meeting of the NHS Board held on Tuesday, 26 July 2005 [GGNHSB(M)05/6] were approved as an accurate record and signed by the Chairman.

ACTION BY

111. MATTERS ARISING FROM THE MINUTES

(i) The Matters Arising Rolling Action List was circulated and noted.

(ii) In relation to Item 95 "East Dunbartonshire CHP Revised Scheme of Establishment", Councillor Collins re-iterated that at the time of the 26 July 2005 NHS Board meeting, East Dunbartonshire Council had not had the opportunity politically to discuss the CHP Scheme of Establishment. The Council had since had its meeting in September and had indicated their view on the matter.

Sir John confirmed that he had received a letter from the Convener of the Council to arrange a meeting to move this forward from this point in terms of partnership working.

NHS Greater Glasgow was committed to progressing the health model CHP - jointly with Local Authority colleagues and would continue to work with Council colleagues to develop that. Councillor Duncan agreed that NHS Greater Glasgow and East Dunbartonshire Council should move on now, in partnership to provide a health only CHP for the population.

(iii) Sir John referred to a tabled paper entitled "New Mental Health (Care and Treatment) (Scotland) Act 2003 – List of Section 22 Approved Medical Practitioners". He apologised for the lateness of the paper but advised that due to the introduction of the new Mental Health (Care and Treatment) (Scotland) Act 2003, relevant approval was sought prior to the Act's implementation on 5 October 2005 – as the next NHS Board meeting was not until 11 October 2005 it, therefore, required to be considered at this meeting.

NOTED

112. OUTCOME OF CONSULTATION ON THE ESTABLISHMENT OF A WEST OF SCOTLAND CARDIOTHORACIC CENTRE AT THE GOLDEN JUBILEE NATIONAL HOSPITAL

A report of the Chief Executive, NHS Greater Glasgow [Board Paper No 05/59] asked the NHS Board to firstly receive an update on the further programme of work taken forward on the proposal and secondly endorse four recommendations based on these proposals put to public consultation but amended to reflected the outcome of that consultation.

Mr Divers thanked Mr R Cleland, Chair of the Project Steering Group, Mr A Faichney, Mr K Hill, Ms J Grant and Mrs S Bustillo for their help in progressing this consultation exercise.

Mr Divers reminded the Board that at the July 2005 NHS Board meeting, an update on the consultation to establish a West of Scotland Cardiothoracic Centre at the Golden Jubilee National Hospital was received. This proposal was first put forward by clinicians in autumn 2003 and doctors and managers from NHS Greater Glasgow, the Golden Jubilee National Hospital and NHS Lanarkshire had been working since then to examine the feasibility of bringing together:

- cardiothoracic services from NHS Greater Glasgow;
- thoracic surgery currently provided at Hairmyres Hospital; and
- planned and non emergency interventional cardiology from Glasgow

at the Golden Jubilee to create a centre of excellence.

ACTION BY

Mr Divers set out the key themes to have emerged from this twelve-week consultation and summarised a range of work that had been undertaken with senior clinical staff to bring these issues to a satisfactory conclusion. In particular, he highlighted the following:

(a) Interventional Cardiology Model – initially, the Consultant Cardiologists expressed different views about the interventional cardiology model. In the series of meetings that had since been held with the cardiologists, a consensus view had now emerged amongst the clinicians that all interventional cardiology should transfer to the Golden Jubilee National Hospital. It was, therefore, recommended that the Board commission a review of interventional cardiology over the coming months. This review should involve surrounding Health Board areas to ensure that any future plans for interventional cardiology being considered by other West of Scotland Health Boards could be taken into account in the development of these options.

Mr Divers emphasised that the provision of interventional cardiology, integrated with cardiac surgery at the Golden Jubilee National Hospital, would enable the provision of a modern multi-disciplinary approach to the treatment of patients with heart disease and a more seamless service for patients.

(b) Golden Jubilee Infrastructure – the proposed West of Scotland Cardiothoracic Centre would not be operating on a stand-alone basis at the Golden Jubilee National Hospital. It was always envisaged that the present infrastructure at the hospital would need to be augmented to meet the demands placed upon it by the proposed transfer of cardiothoracic surgery. Clinical and managerial colleagues had worked through a series of detailed service interface issues to agree the level of clinical support and advice required and how these services would be provided. This work had now largely been concluded with agreement reached on the level of clinical support required and a mechanism to ensure its delivery. In some cases, there remained more than one potential option in relation to service delivery and work was ongoing to finalise the most efficient and cost effective manner in which to deliver all services.

(c) Management Arrangements and Staffing Issues – further discussions had taken place between the partner organisations involved in the proposal on the establishment of a Partnership Board to oversee the strategic direction of the West of Scotland Cardiothoracic Centre. The remit and membership of this Board would now be agreed with the Regional Planning Group at its September meeting and would reflect the close linkages that would be maintained with West of Scotland planning processes.

It had also been agreed that a Clinical Implementation Group would be established to oversee the transfer of the service. This Group would ensure a forum was put in place in which clinical and managerial staff, along with staff-side partners, in all three organisations involved, could participate in the transfer of the service. This Group would also address the key issues of concern to staff relating to terms and conditions of service and potential options available to them as part of the transfer process. It was recommended that this Group be set up swiftly to ensure that the complex issues associated with a major transfer of service could begin to be worked through in detail.

ACTION BY

(d) Financial Arrangements – in taking forward the proposal to bring the West of Scotland Cardiothoracic Surgical Service into a single centre at the Golden Jubilee National Hospital, it had become clear that the affordability of the proposal depended on a collaborative approach on the part of all current funders of the services which were provided at the Glasgow Royal and Western Infirmaries and Hairmyres Hospital. The other significant funder was the National Services Division which funded the heart transplant programme at Glasgow Royal Infirmary.

In terms of the wider proposal to create the West of Scotland Centre at the Golden Jubilee National Hospital, the other important funding partner was the Scottish Executive Health Department which funded the costs of the Golden Jubilee National Hospital.

There was a short to medium term funding pressure associated with the transfer of the Cardiothoracic Surgical Services out of the Glasgow Royal and Western Infirmaries and Hairmyres Hospital. As there were no immediate or short-term plans to reuse the clinical areas which would be vacated, there was a level of cost embedded within these areas (for corporate costs, capital charges and elements of clinical support and support services costs), which could not be released, in full, at this stage.

The West of Scotland NHS Boards had already committed to continuing their current levels of income for these services, recognising the benefits of service sustainability and improvements in patients' amenity which would be delivered at the Golden Jubilee National Hospital. One final meeting of all funding partners was being arranged in October to ensure that all parties would maintain their current income levels until the full release of costs from the vacated areas was released on implementation of Greater Glasgow's and Lanarkshire's future strategic plans.

The detailed costings carried out thus far covered the transfer of the Cardiothoracic Surgical Services which were the key component within the proposal issued for public consultation. The proposed review of Interventional Cardiology would include a detailed costing of the options developed as part of that work.

In summing up, Mr Divers advised that the programme of meetings with senior clinicians that had taken place since the publication of the consultation document had been very productive and had resolved the areas of disagreement which had previously been reported to the NHS Board in July 2005. This further dialogue had highlighted a possible new direction of travel for Interventional Cardiology but one that needed to be further considered and assessed.

The Board of NHS Lanarkshire had already concluded its local consultation and had approved the proposed transfer of Thoracic Surgical Services from Hairmyres to the Golden Jubilee National Hospital.

Mr Cleland, as Chair of the Project Steering Group, referred to the very pro-active consultation exercise which had included a wide range of interested parties and stakeholders. The issues that had arisen had been dealt with in a thorough, open and honest manner. This had led to the positive development of progressing with the proposal and partnership working would continue as a structure was put in place to support the new Centre.

ACTION BY

In response to a question, Dr Cowan confirmed that given the changes in modern medicine, it had become more desirable to have Cardiac Surgery and Interventional Cardiology on the one site. This would provide many advantages to the West of Scotland patients as medicine and technology advanced.

Mr Divers confirmed that the NHS Board paper would be submitted to the West of Scotland Regional Planning Group scheduled for 30 September 2005 to get the Partnership Board established. He clarified that the Clinical Implementation Group would have input from the clinical specialties of acute medicine, A & E, cardiology and general medicine.

DECIDED:

- That the update on the further programme of work taken forward on the proposal be received.

- That the following recommendations, based on the proposals put to public consultation but amended to reflect the outcome of that consultation be endorsed:

1. Adult cardiothoracic inpatient surgical services currently provided at the Western Infirmary and Glasgow Royal Infirmary should be transferred to the Golden Jubilee National Hospital as part of a West of Scotland Cardiothoracic Centre. **Chief Executive**

2. The National Heart Transplant Service currently provided at Glasgow Royal Infirmary should also be transferred as part of the service. **Chief Executive**

3. A review should be carried out over the coming months, involving NHS partners across the West of Scotland, to consider the options for bringing together all Interventional Cardiology at the Golden Jubilee. **Chief Executive**

4. Membership and remit of the Partnership Board and Clinical Implementation Group to be agreed and Groups established as an early priority to take forward the detailed planning and implementation of the moves. **Chief Executive**

113. GREATER GLASGOW NHS NO SMOKING POLICY

A report of the Acting Director of Health Promotion [Board Paper No 05/60] asked the Board to consider whether any changes were necessary to the draft no smoking policy in light of responses received to the consultation.

Ms Borland summarised the responses received and highlighted those aspects of the policy that merited further consideration by the Board in the light of the comments made.

The primary focus of the policy was to protect staff, visitors and patients from the harmful effects of environmental tobacco smoke. It also recognised the exemplar role that NHS Greater Glasgow should play in improving health and reducing smoking rates.

ACTION BY

Of the 108 responses received to the consultation, the majority of respondents were in favour generally of the draft policy but qualified their support by concerns regarding some specific provisions which they considered to be too stringent or too difficult to enforce. The general view expressed was support for the rationale and aims of the policy but fears that, as drafted, it might be too ambitious and as a result would not be implemented effectively.

Ms Borland highlighted the main areas of concern as follows:

- Health and Safety (fire and violence against staff)
- Caring for staff who smoked
- Lack of clarity regarding the phased approach
- Community services
- Smoking cessation support to staff and patients
- Exemptions
- Resources to support effective implementation

Ms Borland referred to the Smoking, Health and Social Care (Scotland) Act 2005 whereby smoking would be banned in public places from 26 March 2006. The Act provided for a number of exemptions to the ban, including designated areas in adult care homes, psychiatric hospitals, hospices and residential accommodation. The Act, therefore, prohibited smoking in all other hospital buildings. Ms Borland noted that while the restrictions within the NHS Board's draft policy were more stringent than those proposed by the Act, it was within the Board's remit to decide to have a policy that was above the minimum standard set out by legislation and, as an employer, the Board would still be expected to protect staff from passive smoking, even in facilities that were considered exempt by the Act.

Whether or not to provide external smoking areas had emerged as a key issue within the consultation. The Working Group established to develop the policy recommended that provision should be made for designated external smoking areas. The provision of external smoking areas was, however, considered to be potentially costly (in providing additional smoking shelters) and contrary to the exemplar role that NHS Greater Glasgow should take in tackling ill health caused by smoking.

Ms Borland provided the following recommendations in the light of the responses received to the consultation:

- The Smoking, Health and Social Care (Scotland) Bill 2005 prohibited smoking in hospitals and health care premises. As such, the Board could not allow further exemptions to be made.

- The Board amend the draft policy to allow smoking in grounds in designated areas only which would be located at a distance of at least six metres from any buildings for one year following the introduction of the policy.

- A Policy Implementation Group be established to draw up a detailed implementation plan which would address areas of concern and provide a framework for the effective implementation of the policy.

- The target date from which the policy be effective was 26 March 2006 – to coincide with the coming into force of the Smoking, Health and Social Care (Scotland) Bill 2005.

Mr McLaughlin commended the Board's approach to no smoking and recognised the role that NHS Greater Glasgow must play in improving health and reducing smoking rates.

ACTION BY

Councillor Handibode agreed with the aims of the policy but was concerned about the difficulties in policing its implementation. Ms Borland advised that such a matter would be considered by the Policy Implementation Group that would be set up. Furthermore the Group's work, particularly in relation to policy enforcement, would be informed by the experience of the health service in the Republic of Ireland, where the smoking in public places ban had operated for just over a year.

DECIDED:

1. That the outcome of the public consultation exercise be noted.

2. The Smoking, Health and Social Care (Scotland) Act 2005 prohibited smoking in hospitals and health care premises. The Board noted, therefore, that it could not allow further exemptions to be made. **Acting Director of Health Promotion**

3. An amendment to the policy to allow smoking in grounds in designated areas only (which would be located at a distance of at least six metres from any buildings) for one year following the introduction of the policy be approved. **Acting Director of Health Promotion**

4. A Policy Implementation Group to draw up a detailed implementation plan which would address areas of concern and provide a framework for the effective implementation of the policy be established. **Acting Director of Health Promotion**

5. That the target date from which the policy should be effective be 26 March 2006 – to coincide with the coming into force of the Smoking, Health and Social Care (Scotland) Act 2005 be approved. **Acting Director of Health Promotion**

114. COMMUNITY HEALTH PARTNERSHIPS WITH NHS LANARKSHIRE SCHEME OF ESTABLISHMENT

A report of the Director of Planning and Community Care [Board Paper No 05/61] asked the Board to approve, in principle, the proposed Scheme of Establishment for Community Health Partnerships with NHS Lanarkshire, with submission to the Scottish Executive contingent on further development work to agree and finalise structures and satisfactorily address the concerns articulated.

Ms Renfrew introduced the draft Scheme of Establishment for Community Health Partnerships (CHPs) with NHS Lanarkshire. The Scheme of Establishment set out proposals for the development of two CHPs, one North Lanarkshire CHP and one South Lanarkshire CHP.

Discussions had taken place over a number of months with NHS Lanarkshire to agree CHP arrangements that would include the South Lanarkshire population of NHS Greater Glasgow (Cambuslang and Rutherglen) and the North Lanarkshire population of NHS Greater Glasgow (Moodiesburn, Muirhead, Stepps and Chryston). In July 2005, NHS Lanarkshire agreed a proposal to create two CHPs that would bring single authority-wide structures for North and South Lanarkshire responsible for the management and delivery of local health services and the health improvement of their populations. Each CHP would develop locality arrangements that would facilitate local service delivery and engagement with the local population within a CHP-wide framework.

ACTION BY

In putting forward these CHP proposals, Ms Renfrew restated that NHS Greater Glasgow would remain responsible for the populations of Cambuslang and Rutherglen and of the northern corridor. It was, therefore, critical that the Board was satisfied that the proposed CHP arrangements were constructed in a way which assured that the CHPs would be effective at a macro level but also that the locality arrangements within them enabled appropriate local autonomy and decision making.

Ms Renfrew highlighted areas of concern which needed to be addressed before NHS Greater Glasgow could endorse the Scheme of Establishment for submission to the Scottish Executive Health Department for ministerial approval. The concerns included the following:

- Locality working
- Corporate functions
- Management arrangements
- Governance
- Whole systems issues

She advised that this, in principle approach, was proposed in order that there was not an unnecessary delay in the submission process by a requirement for further GGNHS Board consideration.

In response to a question from Mrs Stewart, Ms Renfrew advised that she was confident NHS Lanarkshire would want to agree a Scheme of Establishment with NHS Greater Glasgow. Furthermore, the Scottish Executive Health Department required that the Scheme be signed off by both Boards.

In response to a question from Dr Groden, Ms Renfrew confirmed that local interests within NHS Lanarkshire had been involved in the preparation of these proposals.

DECIDED:

1. That the proposed Scheme of Establishment for Community Health Partnerships within NHS Lanarkshire, with submission to the Scottish Executive contingent on further development work to agree and finalise structures and satisfactorily address the concerns articulated be approved in principle. **Director of Planning and Community Care**

2. That the need for an update on the outcome of the further development work at the October 2005 Board meeting be noted. **Director of Planning and Community Care**

115. GARTNAVEL ROYAL HOSPITAL – CONTRACT FOR PROVISION OF HOSPITAL

A report of the Acting Chief Executive, Primary Care Division [Board Paper No 05/62] sought approval to the contract for the project for Gartnavel Royal Hospital, following approval of the Full Business Case at the meeting of the Board on 22 February 2005.

Ms Crocket welcomed Mr D Thomson, Associate Director of Finance, Primary Care Division and Mr G McMenemy, Solicitor, McClure Naismith who had been involved in the formation of the contract.

ACTION BY

Ms Crocket provided Members with an update on the current status of the project. She explained that the project was to be entered into pursuant to the Government's Private Finance Initiative and that the purpose of the project was to create a mental health hospital which would provide services as discussed and outlined in the Minutes of the meeting of 22 February 2005. Copies of the principal documents to be entered into by the Board pursuant to the project (the "Project Document" listed below) were available to Members for their consideration. Mr Griffin explained that the Project Documents were not yet in their final form and would be subject to minor amendments as advised necessary by the Board's external advisors. No amendments were anticipated which would detract materially from the template documentation applicable to NHS Projects of this nature. He explained that the project was moving towards financial close.

The "Project Documents" referred to above were as follows:

1. Project Agreement between the Board and Robertson Health (Gartnavel) Limited.

2. Funders Direct Agreement between the Board, The Governor and Company of the Bank of Scotland and Robertson Health (Gartnavel) Limited.

3. Construction Direct Agreement between the Board, The Governor and Company of the Bank of Scotland, Robertson Health (Gartnavel) Limited and Robertson Construction Central Limited.

4. Services Direct Agreement between the Board, The Governor and Company of the Bank of Scotland, Robertson Health (Gartnavel) Limited and Robertson Facilities Management Limited.

5. Independent Tester Contract amongst the Board, Robertson Health (Gartnavel) Limited and Davis Langdon LLP.

6. Collateral Warranties from the professional Team in favour of the Board.

In response to a question from Councillor Handibode, Ms Crocket confirmed that cleaning and catering services would be provided in-house by NHS Greater Glasgow.

In response to a question from Mrs Stewart, Mr Griffin confirmed that the letter from PricewaterhouseCoopers dated 4 March 2005 (Board papers page number 120) was a standard letter.

DECIDED:

1. That approval for the Board to enter into the Project Documents and additional documentation required in connection with the project as advised by the Board's external advisors be given. **Acting Chief Executive, PCD**

2. That any two from the Chief Executive, the Acting Director of Finance, the Director of Planning and Community Care and Acting Chief Executive for the Primary Care Division, be authorised to consider and agree any amendments after the date of this meeting, having considered the advice of the Board's external advisors (including agreement of the final pricing amendments to the Project Documents) be agreed. **Acting Chief Executive, PCD**

ACTION BY

3. That any two from the Chief Executive, the Acting Director of Finance, the Director of Planning and Community Care and Acting Chief Executive for the Primary Care Division, be authorised to sign on behalf of the Board the Project Documents (subject to such amendments to the Project Documents as shall be agreed by any one of the Chief Executive, the Acting Director of Finance, the Director of Planning and Community Care and Acting Chief Executive for the Primary Care Division having considered the advice of the Board's external advisors) and any additional documentation required in connection with the Project as advised by the Board's external advisors be agreed. **Acting Chief Executive, PCD**

4. That Mr D Griffin, Acting Director of Finance be authorised as the named individual on behalf of Greater Glasgow NHS Board for the purpose of the insurance proceeds account to be opened in terms of the Project Agreement and the Insurance Proceeds Account Agreement be agreed. **Acting Chief Executive, PCD**

5. That the Chairman be requested to produce a certified copy of the Minute of the proceedings of the meeting as verification that approval has been granted be agreed. **Acting Chief Executive, PCD/ Chairman**

116. PROGRESS SO FAR AND THE FUTURE ROLE OF THE SERVICE REDESIGN COMMITTEE

A report of the Director of Planning and Community Care [Board Paper No 05/63] asked the Board to re-emphasise the importance of embedding the objective of service improvement across the activities of the reformed NHS Greater Glasgow and approve the establishment of the proposed arrangements to continue and strengthen a focus of service improvement but discontinue the present Service Redesign Committee.

Ms Renfrew reminded the Board that Service Redesign Committees were required to be created by the "Partnership for Care" White Paper. The Greater Glasgow Service Redesign Committee was established at the end of 2003 – the NHS Board carefully considered, prior to finalising the role and remit of the Committee, the context in Greater Glasgow. These important points of context created a debate about the function of the proposed Committee. In trying to map out a coherent, meaningful programme of activity for a Committee, this highlighted a number of dilemmas and the Board concluded that the Committee should have a co-ordinating and facilitating role. After nearly a year of its operation, the Committee took time out to consider its operation. What became clear was that NHS Greater Glasgow's arrangements were very different from other Board areas particularly because:

- NHS Greater Glasgow had a Local Health Plan Steering Group which presided over a complex set of planning arrangements which focussed on Local Authorities, Managed Clinical Networks and major priority areas such as Coronary Heart Disease and Stroke.

- NHS Greater Glasgow had a Public and Patient Information Subcommittee which led work in this area of responsibility chaired by a Board Non Executive.

- NHS Greater Glasgow's major clinical strategies for mental health, acute services and primary care had been developed through processes established specifically for that purpose.

ACTION BY

The Committee's conclusion following a number of discussions was that it should not continue in its present form but that there were a number of challenges which the Board needed to ensure it was organised to meet. Ms Renfrew outlined these and highlighted proposals for further development, to achieve these objectives including:

- Organising for improvement
- Accessible information
- Links to Patient Focus Public Involvement
- Electronic staff sharing
- Planning and review process
- Corporate Governance and performance management
- Annual Forum

The fact that a Service Redesign Committee had not been an effective mechanism in Greater Glasgow did not imply that service redesign was not at the heart of the Board's commitments and priorities. Rather, it reflected the scale and complexity of our organisation and the challenge of a devolved not centralised approach. It was critical as NHS Greater Glasgow moved to its new organisational and governance arrangements, that the Board could be assured that service change was being driven in the interests of patients.

As Chair of the Service Redesign Committee, Mr McLaughlin echoed Ms Renfrew's summary and thanked those who had participated in the Committee. He hoped they would become actively involved in the new proposals to drive service change.

In response to a question from Mr Goudie, Ms Renfrew confirmed that the short-life working group set up to establish what skills and tools were required by frontline staff to equip them to drive service improvement would report back to the Board following conclusion of its work by April 2006.

DECIDED:

1. The importance of embedding the objective of service improvement across the activities of the reformed NHS Greater Glasgow was re-emphasised. **Director of Planning and Community Care**

2. The establishment of the proposed arrangements to continue and strengthen a focus on service improvement but discontinue the present Service Redesign Committee was approved. **Director of Planning and Community Care**

3. That the Working Group report be submitted to the NHS Board in April 2006. **Director of Planning and Community Care**

117. WAITING TIMES

A report of the Director of Planning and Community Care [Board Paper No 05/64] asked the Board to note the progress made in meeting national waiting time targets.

Ms Renfrew led the Board through the waiting time targets and the performance across NHS Greater Glasgow – referring to the availability status codes, that referred to patients who had asked to defer admission.

Mr Divers advised that waiting times were subject of monthly scrutiny by the relevant NHS Chief Executives and they were scheduled to have their next meeting that afternoon.

NOTED

ACTION BY

118. QUARTERLY REPORT ON COMPLAINTS : APRIL - JUNE 2005

A report of the Head of Board Administration and Divisional Chief Executives [Board Paper No 05/65] asked the Board to note the quarterly report on NHS complaints in Greater Glasgow for the period 1 April to 30 June 2005 and note that it would also be considered by the Health and Clinical Governance Committee at its next meeting.

Mr J Hamilton reported that this was the first quarterly complaints report providing a commentary and statistics since the introduction of the new NHS Complaints Procedure on 1 April 2005.

By way of a summary there were two requests for Independent review still being handled throughout NHS Greater Glasgow, both in North Glasgow. The progress of these would be reported to the NHS Board for information until they were completed.

Mr Hamilton led the Board through the report highlighting the new areas of reporting which included an emphasis on action taken/lessons learned for patient care and service improvements made as a result of complaints. Furthermore, the report also gave an indication of the Ombudsman's involvement and formal investigation of any NHS Greater Glasgow complaints.

Mr Hamilton confirmed that Citizens Advice Direct and the Citizens Advice Bureau across NHS Greater Glasgow provided patients with independent support and advice should they wish it.

NHS Greater Glasgow had been approached by NHS Lanarkshire to ask if they could share the pool of Conciliators. Given that the frequency of requests within both areas for conciliation was small, this seemed a reasonable request and would allow the Conciliators to build up a greater level of experience and potentially increase uptake. A refresher training day for the Conciliators had been organised for 9 November 2005.

DECIDED:

That the Quarterly Report on NHS complaints in Greater Glasgow for the period 1 April to 30 June 2005 be noted.

119. (a) MENTAL HEALTH (SCOTLAND) ACT 1984 – LIST OF APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 05/66] asked the Board to approve the following medical practitioners employed by the Primary Care Division of NHS Greater Glasgow to be authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984:

Dr Andrea Williams
Dr Dipali Mantry

ACTION BY

DECIDED:

That the two above named medical practitioners be approved and authorised for the purpose of Section 20(1)(b) and 39(b) of the Mental Health (Scotland) Act 1984. **Acting Chief Executive, PCD**

(b) NEW MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

Sir John referred to the tabled paper which asked the Board to approve medical practitioners listed in Appendix A and employed by the Primary Care Division of NHS Greater Glasgow to be authorised for the purpose of Section 22 of the new Mental Health (Care and Treatment) (Scotland) Act 2003. He also asked the Board that he be given delegated authority to approve the list of names in Appendix B for the purpose of Section 22 of the new Mental Health Act, once they had completed the necessary training and that, thereafter, the names be endorsed at the next available NHS Board meeting.

DECIDED:

- That the medical practitioners listed in Appendix A be authorised for the purpose of Section 22 of the new Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Acting Chief Executive, PCD**

- That the Chair be given delegated authority to approve the list of names in Appendix B for the purpose of Section 22 of the new Mental Health Act, once they had completed the necessary training be agreed. **Acting Chief Executive, PCD/ Chairman**

120. PERFORMANCE REVIEW GROUP MINUTES

The Minutes of the Performance Review Group meeting held on Tuesday 16 August 2005 [PRG(M)05/04] were noted.

NOTED

121. YORKHILL DIVISIONAL MANAGEMENT TEAM MINUTES

The Minutes of the Yorkhill Divisional Management Team meeting held on Friday 17 June 2005 [Board Paper No 05/67] were noted.

NOTED

122. SOUTH GLASGOW DIVISIONAL MANAGEMENT TEAM MINUTES

The Minutes of the South Glasgow Divisional Management Team meeting held on Wednesday 29 June 2005 [Board Paper No 05/68] were noted.

NOTED

ACTION BY

123. PRIMARY CARE DIVISIONAL MANAGEMENT TEAM MINUTES

The Minutes of the Primary Care Divisional Management Team meeting held on Thursday 30 June 2005 [PCDMIN2005/05] were noted.

NOTED

The meeting ended at 12.15 pm

GGNHSB(M)06/1
Minutes: 1 - 19

GREATER GLASGOW NHS BOARD

Minutes of a Meeting of the Greater Glasgow NHS Board held in the Board Room, Dalian House, 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 21 February 2006 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Bannon
Professor D Barlow
Mr R Cleland
Councillor J Coleman
Councillor D Collins (to Minute 9)
Dr B N Cowan
Ms R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Mr D Griffin
Mr P Hamilton
Councillor J Handibode
Mrs S Kuenssberg CBE
Ms G Leslie
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Ms A Paul
Mr I Reid
Mr A O Robertson OBE
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Executive, South Division
Ms S Gordon	..	Secretariat Manager
Ms J Grant	..	Acting Chief Executive, North Glasgow Division
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Ms C Renfrew	..	Director of Planning and Community Care
Mr D Walker	..	Head of Performance and Corporate Reporting

ACTION BY

1. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Ms R Crocket, Dr R Groden, Councillor A White and Dr L de Caestecker.

The Chairman welcomed Helen Byrne to her first meeting as Director of Acute Services Strategy, Implementation and Planning.

2. CHAIRMAN'S REPORT

Sir John referred to the important role of governance placed on the NHS Board (and the crucial role of Non Executive Board Members) in driving forward the lessons learned from isolated, but tremendously regretful patient incidents. It was paramount that safety protocols improved at every opportunity to enhance patient care and outcome.

ACTION BY

The NHS Board's new Clinical Governance Committee, put in place as a result of single system working, was well placed to ensure this agenda retained momentum.

NOTED

3. CHIEF EXECUTIVE'S UPDATE

(i) Sir John and Mr Divers had attended the third in a series of meetings with Renfrewshire Council to establish its Community Health Partnership (CHP). Catriona Renfrew and Anne Hawkins would continue this dialogue to progress its establishment. Similarly, meetings had begun with Inverclyde Council's Chief Executive exploring potential models to progress the establishment of a CHP.

(ii) Mr Divers reported that detailed discussions were continuing with NHS Lanarkshire, NHS Ayrshire and Arran and NHS Forth Valley on their respective clinical strategies. He was confident that with these arrangements for regional co-ordination in place each NHS Board understood the impact of the potential changes in light of outcomes from their public consultations and any likely knock-on effect this may have on a regional basis.

(iii) Mr Divers and Ms Byrne had attended a public consultation meeting on NHS Lanarkshire's "Picture of Health" in Muirhead on the previous evening. They had provided reassurance to this community that their continued acute hospital care would be provided within Greater Glasgow and had assured those in attendance that there would be improved engagement with their community from the North Lanarkshire CHP.

(iv) Mr Divers referred to the work which had been taken forward by Dr Cowan, Medical Director, on the provision of about twelve short stay beds for planned procedures at the new Stobhill and Victoria Hospitals. NHS Board Members had endorsed this work at their recent Seminar.

NOTED

4. MINUTES

On the motion of Mr A O Robertson, seconded by Mr R Cleland, the Minutes of the meeting of the NHS Board held on Tuesday, 20 December 2005 [GGNHSB(M)05/9] were approved as an accurate record and signed by the Chairman.

5. MATTERS ARISING FROM THE MINUTES

The Matters Arising Rolling Action List was circulated and noted.

NOTED

ACTION BY

6. DELIVERING FOR HEALTH : WHITE PAPER

A report of the Chief Executive [Board Paper No 06/01] asked the NHS Board to receive the "Delivering for Health – White Paper" from the Scottish Executive which set out national policy for the NHS and reapplied its founding principles and sought to shift the balance of care, focussing on tackling the causes of ill health and providing care which was quicker, more personal and closer to home. The NHS Board was also asked to discuss the steps in taking forward the plans for implementation and note that further updates would come to the NHS Board as the various strands of implementation were developed.

Mr Divers advised that the "Delivering for Health" document applied the findings of Professor Kerr's "Building a Health Service Fit for the Future : A National Service Framework for Service Change in the NHS in Scotland" report in a national context. It set out a programme of action, reducing reliance on episodic, acute care in hospitals for treating illness, moving towards a system which emphasised a wider effort on improving health and well being. It described the main actions that would be taken within current spending plans to implement the Kerr Report.

The Minister and the Chief Executive of NHSScotland were now putting in place the detailed arrangements for implementing "Delivering for Health" and it was anticipated that a Health Department Letter (HDL) setting out the implementation arrangements would be issued shortly. Part of the approach to implementation would involve a Director from the Health Department working with a Board Chief Executive to lead the development of the more detailed implementation plan for each of the main strands within the paper.

Mr Divers led the Board through the document, summarising its main objectives and highlighting early priorities for action which affected NHS Greater Glasgow. He set out where the NHS Board was now and summarised progress to date as well as identifying a future model of care. To deliver such a model, there were four big priorities for investment and reform to shape the NHS in this way:

- The NHS as local as possible.
- Systematic support for people with long-term conditions.
- Reducing the inequalities gap.
- Actively managing hospital admissions.

The White Paper set out in some detail how each of these four priorities would be progressed.

In terms of delivering services for the whole of Scotland, integration would be promoted to achieve the objectives of high quality services and better productivity. Service co-location would support the aim of integration but much more important was the development of a culture and the creation of working practices that enabled co-operation and teamwork. Underpinning the changes was a need for an appropriate workforce. Regional Workforce Plans had been produced for January 2006 with Board Workforce Plans due by April 2006 and a National Workforce Plan by December 2006. The aim was to ensure NHSScotland was maximising the efficiency and effectiveness of its use of the workforce. It allowed assessment of the numbers of staff required for the future, the type of staff required, how they would work differently and the changes in education, training and regulation needed.

ACTION BY

In terms of taking this forward in NHS Greater Glasgow, Mr Divers confirmed that the NHS Board embraced the direction of travel set out in the White Paper and significant work was already underway to ensure the changes recommended were taken forward. There were three main strands of work which were urgent priorities in the coming months:

- The work on unscheduled care which was being taken forward Regionally.
- The implementation of two Prevention 2010 priorities within Glasgow Community Health Care Partnerships (CHCPs) to address anticipatory care.
- The pattern of some highly specialist tertiary children's hospital services.

Mr Divers confirmed that further update papers would come to the NHS Board in the coming months as the detailed plans for implementation became clearer following the issue of the forthcoming Health Department Letter (HDL).

Sir John referred to the Prevention 2010 programme whereby the Minister for Health and Community Care had decided that NHS Greater Glasgow should host two of the five pilot schemes being funded. These schemes would be taken forward in the East and North CHCPs within the City of Glasgow. The programmes would focus on the most deprived general practice population within each of these two localities. Additional resources made available would enable Primary Care Teams to spend more time in assessing the needs of individuals who currently presented while creating capacity also to ensure more contact with others who did not currently regularly attend general practice.

Mr P Hamilton referred to a recent Glasgow City CHCP event which focussed on tackling health inequalities. This had provided a greater insight into understanding at locality level how challenging these issues were and where focus had to be sharpened. He hoped that such events would be taken forward with the other CHPs as it had been an encouraging development and learning experience.

DECIDED:

(i) That the "Delivering for Health – White Paper" from the Scottish Executive be received. **Chief Executive**

(ii) That further updates would come to the NHS Board as the various strands of implementation were developed. **Chief Executive**

7. LOCAL DELIVERY PLAN 2006/07

A report of the Director of Planning and Community Care and Director of Finance [Board Paper No 06/02] set out the process for the implementation of a new system of Local Delivery Plans.

Ms Renfrew referred to the more rigorous approach to performance management taken by the Scottish Executive Health Department (SEHD) in its introduction of Local Delivery Plans 2006-07.

The Local Delivery Plan was designed as a performance and delivery agreement between the SEHD and each individual NHS Board. It was built upon a set of key objectives, targets and measures which formed the core of the Ministerial agenda for health over the next three years. The Local Delivery Plan system was being accompanied by a re-organisation within the SEHD which consolidated performance related activity across the Executive into a new Local Delivery Unit under a single Director of Delivery. The new system replaced the previous arrangements of the Performance Assessment Framework and Local Health Plan.

For 2006-07, the Scottish Executive had asked NHS Argyll and Clyde to prepare its own separate Local Delivery Plan. As such, NHS Greater Glasgow's Local Delivery Plan would incorporate Clyde for the first time in 2007-08. Ms Renfrew led the NHS Board through the format of the Local Delivery Plan which had twenty-eight targets, informed by thirty-two key measures distributed across four objectives, namely:

- health improvement
- efficiency and effectiveness
- access
- treatment

For some targets, an alternative trajectory prepared by NHS Greater Glasgow had been inserted informed by local experience and knowledge. These would require to be agreed with the Local Delivery Unit. Where no alternative was provided, the SEHD proposed trajectory was accepted. The Local Delivery Plan included sections on the 26-week target for inpatients and day cases and outpatients which was achieved by December 2005 and which was now a national standard.

Ms Renfrew outlined the implications for the NHS Board. She restated that the Local Delivery Plan had been pulled together in a very short timescale and the Board's financial allocation information for 2006/07 had only been received the day before this NHS Board meeting. As such, a number of elements required further detailed exchanges with the SEHD including risks, funding, information, balance, cultural and technical elements.

This Local Delivery Plan, together with its financial plan, were due to be submitted to the SEHD by 28 February 2006 with a view to being operational from 1 April 2006 following negotiations with the SEHD during March. Performance against NHS Board planned trajectories would be tracked by the SEHD on a monthly basis as far as possible beginning in the summer of this year. The SEHD would concentrate on areas where there was deemed to be a significant and/or sustained deviation from planned performance and would seek assurance from the NHS Board on remedial action for improvement. From 2007, the results of the Local Delivery Plan process would form a major component of the NHS Board's annual review with the Minister.

Mr Griffin led the NHS Board through the Indicative Financial Plan for 2006/07. It began with an assumed opening financial position based on the 2005/06 outturn. The plan included entries of funding inflows and expenditure outflows. Mr Griffin highlighted the anticipated additional funding, inflation costs and service commitment costs. The overall financial projections resulted in a deficit of £10.2M at this stage and, therefore, further work was required to get to a balance. He highlighted two points:

- The 2006/07 Indicative Financial Plan included only NHS Greater Glasgow's commitments – separate discussions were taking place around the eventual incorporation of the element of Argyll and Clyde Health Board.

ACTION BY

- The Indicative Financial Plan did not take account of the new Cardiothoracic Centre at Clydebank and further discussions would take place with SEHD regarding this.

In response to a question from Mrs Stewart, Ms Renfrew confirmed that NHS Greater Glasgow had seen the NHS Argyll and Clyde's Local Delivery Plan but this would be developed separately for the 2006/07 year.

Mr Robertson commented on the rate of growth projected for prescribing costs (both in Primary Care and Acute) which was being managed at a lower rate of growth compared to earlier years.

Mr Walker commented on the huge variety of targets but explained that most of them were not new to the NHS system; most were being focussed on already but the new single system structure in NHS Greater Glasgow brought about responsibility for performance management in a more organised way. He commented on the negotiation that would take place with the SEHD regarding some differing opinions on the trajectories and explained that the NHS Board would not sign up to something that was undeliverable.

Sir John clarified that although CHCPs and CHPs were devolved, they would have responsibility to meet their local targets and contribute to meeting performance on an NHSGG wide basis through the NHS Board. Professor Barlow commented that this way of reporting would provide a bottom-up approach.

In response to a question, Mr Griffin explained that the financial plan was a working document at this stage with some cost estimates still to be firmed up. This would be done during the following three to four week period.

Councillor Handibode sought clarity within the document on what particular targets lay with CHPs as part of a local service. He cited Smoking Cessation as an example. This formed part of the CHP responsibility but the paper did not make that clear. Ms Renfrew agreed to amend the Local Delivery Plan to reflect where responsibility for meeting the targets lay. **Director of Planning and Community Care**

DECIDED:

- That the draft Local Delivery Plan be approved for submission to the Scottish Executive Health Department subject to changes noted above and including work to finalise the Plan with the SEHD. **Director of Planning and Community Care/ Director of Finance**

- That progress in developing the NHS Board's Financial Plan 2006/07 be noted.

- That progress on the Local Delivery Plan, together with the outcome of monitoring by the Executive's Local Delivery Unit, would be reported regularly to the NHS Board or Performance Review Group. **Director of Planning and Community Care**

8. NHS ARGYLL AND CLYDE INTEGRATION

A report of the Chief Executive [Board Paper No 06/3] asked the NHS Board to note progress in exchanges with the Scottish Executive Health Department (SEHD) over the NHS Argyll and Clyde integration.

ACTION BY

Mr Divers set out the issues which had emerged from the NHS Board's work to date through the joint structures which were established to manage the dissolution of NHS Argyll and Clyde and its integration into the responsibilities of NHS Greater Glasgow and NHS Highland. He also provided an update on the NHS Board's progress in reaching agreement with the SEHD on how these issues would be addressed in a way which did not create detriment to the present Greater Glasgow population in either service or financial terms.

In order to assess and understand the financial position of NHS Argyll and Clyde, a joint financial planning subgroup was formed between the three Boards. A period of intensive work led to a number of detailed conclusions for discussion with the SEHD. The review highlighted a number of significant financial issues, including high risks associated with elements of the present Argyll and Clyde savings plan, most particularly, savings in community care services which were not agreed with the Local Authorities. There were also a number of emerging pressures.

Mr Divers had met with the SEHD Chief Executive and Acting Director of Finance to discuss NHS Greater Glasgow's appraisal with the following proposals:

- Each NHS Board should receive a core allocation based on dividing the total Argyll and Clyde Arbuthnott share between Highland and Greater Glasgow on an Arbuthnott formula basis.

- Sources of funding and applications which related to the NHS Board's new responsibilities should be distinct from the existing Greater Glasgow financial flows during the agreed transitional period.

- There should be a formal agreement with the SEHD to provide the necessary financial support for a three year period, with a commitment from NHS Greater Glasgow to develop detailed plans to return to spending within the appropriate Arbuthnott allocation.

In addition to these issues regarding savings, a series of further points for discussion were raised and Mr Divers anticipated that further similar issues would continue to emerge over the next few months. In particular it had become clear in a number of key services areas that current Argyll and Clyde residents had access to substantially lower levels of service than would be the case for the population served by NHS Greater Glasgow.

Mr Divers confirmed that the discussions with the SEHD had been productive. There was an understanding of the substantial financial challenges associated with the Clyde responsibilities and a willingness to work with NHS Greater Glasgow to deal jointly with these. This included a commitment to establish a timely process to reach a detailed agreement on transitional finance before the Local Delivery Plan was signed off. This progress enabled NHS Greater Glasgow to establish a new financial planning process with Local Authorities based on existing spending patterns.

In terms of human resources issues, Mr Divers summarised a number of problems and potential risks including:

- Potential voluntary redundancy and redeployment costs of NHS Argyll and Clyde staff who could not be matched into Greater Glasgow or Highland roles.

- The impact of the NHS Argyll and Clyde voluntary early retirement and redundancy programme though which in excess of 150 administrative and managerial staff, had left or were leaving the Board.

ACTION BY

- A further risk associated with the redundancy programme lay in the gaps in knowledge and expertise as NHS Greater Glasgow aimed to develop a more detailed understanding of the underlying position which it may inherit.

- Interim clinical staffing arrangements not fully reflected in recurring budgets.

Mr Divers confirmed that the NHS Board would be kept up to date as discussions needed to progress rapidly over the next few weeks.

Mr Sime, on behalf of the Area Partnership Forum, welcomed this paper and commended the excellent negotiations that had taken place. He was particularly reassured to note that the Minister had made a commitment regarding the transitional funding arrangements.

Councillor Collins appreciated the challenges that lay ahead and commented that NHS Greater Glasgow should not inherit a deficit financial position.

Mr McLaughlin was also reassured by the content of the paper but asked about the loss of organisational knowledge from NHS Argyll and Clyde and the cultural challenge that lay ahead in bringing both organisations together. Mr Divers referred to the Clyde element of NHS Argyll and Clyde whereby restructuring had begun to include one acute hospital division, two CHPs and corporate support services. Appointments were already being be made and staff were committed to getting themselves up to speed regarding knowledge about the area. Mr Divers recognised that organisational development for the future would be crucial to progress this.

Ms Dhir raised the concern that patients from NHS Argyll and Clyde had to see a better service following the dissolution of its Board or they would wonder why there had been a change in the first place. Mr Divers agreed with this which had come up at some of the public meetings he had attended. In this regard, NHS Greater Glasgow was committed to providing equitable care across the whole population. There was recognition that this could not be established from day one but that a strategy had been put in place to offer such re-assurance. Early key priority areas would be focussed on first.

Mrs Smith commended the systematic process for managing the various challenges that lay ahead.

NOTED

9. SITING OF NEW CHILDREN'S HOSPITAL – PROPOSED CONSULTATION PROCESS

A report of the Director of Planning and Community Care [Board Paper No 06/04] asked the NHS Board to note the proposed consultation process for the new children's hospital presently under discussion with the Scottish Health Council

Ms Renfrew explained that the NHS Board anticipated the Minister would shortly release a recommendation on the siting of the new children's hospital. She set out the NHS Board's proposals to consult on the siting of the new hospital and related closure of the Royal Hospital for Sick Children.

She emphasised that this consultation was the beginning of an extensive process to involve patients, parents and voluntary organisations in the design and development of the new facility. The process and content of the consultation were complex in drawing together a number of strands of prior process and engagement including:

ACTION BY

- Pre-consultation and development work for the Maternity Services Strategy in 2003.

- Formal public consultation on that strategy in late 2003/early 2004.

- Work of the Calder Ministerial Group between September 2005 and January 2006.

- Option appraisal process on potential children's hospital sites run by NHS Greater Glasgow in October 2005.

Ms Renfrew described the proposed process for consultation which was primarily based on written material distributed to a wide range of key stakeholders and a major public workshop. The proposed consultation period would be eight weeks – enabling a report to be lodged with the Minister as soon as possible in order that the detailed planning of the hospital could begin without further delay.

Mr P Hamilton welcomed the consultation with the Scottish Health Council particularly at the earliest stages of defining the consultation process. Given the circumstances of the ongoing debate around this, he considered the eight-week consultation process to be adequate particularly as this was not the start of the debate but the debate coming to an end once the outcome of the Calder Group had been reported to the Minister.

Ms Byrne confirmed that work would also be driven by Niall McGrogan, Head of Community Engagement. In this regard, Mrs Kuenssberg reflected that thought should be given on how to engage with young people and children and how best they could be involved in the planning processes. Sir John echoed the need to involve young people as appropriate.

NOTED

10. PATIENT FOCUS AND PUBLIC INVOLVEMENT IN NHS GREATER GLASGOW

A report of the Chair, Involving People Committee [Board Paper No 06/5] asked the Board to note the progress made by the Involving People Committee in delivering the Patient Focus Public Involvement (PFPI) agenda and consider how, in future, the Involving People Committee should discharge its remit in the context of a re-organised and enlarged NHS Greater Glasgow.

Mr P Hamilton described the background of the Committee and its remit which was to ensure NHS Greater Glasgow discharged its legal obligations to involve, engage and consult patients, the public and communities in the planning and development of services and in decision making about the future pattern of services.

He went on to describe the Committee's progress with key issues and projects such as:

ACTION BY

- Involving People Action Plan
- Involving People Network
- Priorities Resulting from the 2004/05 Performance Assessment Framework
- Communications
- Our Health Events
- Acute Services Information Campaign
- Major Consultation/Engagement Exercises

There were a number of points on which the Committee would like to encourage discussion over the coming months and these included:

- Mainstream Integration of PFPI Principles
- The Scottish Health Council
- Performance Assessment Framework Submission for 2005/06
- Upcoming Challenges and Priorities
- Re-organisation – an Opportunity
- The Way Forward

In conclusion, he commented that external assessment on the Committee's performance over the past two years in relation to the PFPI agenda had been very positive – due to the commitment, professionalism and openness of NHS Greater Glasgow's staff. The Committee was, nonetheless, not complacent and recognised and welcomed the challenges ahead. In this regard, Mr P Hamilton thanked the Corporate Communications Team and members of the Involving People Committee for the commitment they had shown since Autumn 2004.

DECIDED:

- That the progress made by the Involving People Committee in delivering the Patient Focus Public Involvement (PFPI) agenda be noted.

- That the outcome of regular discussions between the Scottish Health Council and the Involving People Committee and the submission made in relation to the 2005/06 Performance Assessment Framework be noted.

- That the future of the Involving People Committee, its remit and how PFPI would be achieved in the context of a re-organised and enlarged NHS Greater Glasgow be considered. **Chair, Involving People Committee**

11. ANNUAL MONITORING REPORT – FREEDOM OF INFORMATION

A report of the Head of Board Administration [Board Paper No 06/06] asked the NHS Board to note the first Annual Monitoring Report on the impact of the Freedom of Information (Scotland) Act 2002 for NHS Greater Glasgow.

Mr J C Hamilton outlined the action taken to prepare for the introduction of the Freedom of Information (Scotland) Act 2002 and summarised the requests for information received by NHS Greater Glasgow in the first year of operation.

204 requests had been received in the first twelve months of the Act's operation, 86.2% of which had been dealt with within the statutory timescale of 20 working days. The figures indicated a fairly consistent number of enquiries being received throughout 2005. Of the 204 cases, an exemption was cited on 28 occasions where a request for information was refused. Mr Hamilton went on to describe the broad range of subjects that had been covered by the requests received so far and the most common exemptions applied under the Act.

ACTION BY

To date, there had been five requests for an internal review received and completed in the course of 2005. From these, the original decision in two cases were upheld in full and in three cases the decision was upheld in part. The Freedom of Information Commissioner had had a total of four cases referred to him from people dissatisfied with the response of NHS Greater Glasgow. One case had been withdrawn after discussion and the Commissioner did not report on the case, the other four were with the Commissioner who had yet to report on his findings.

One year on, the Scottish Executive had launched a consultation of the operation of the Act. Mr Hamilton referred to the "Pack for Respondents" which provided a full list of the questions raised in the consultation and there was encouragement that this be used as a template for responding. NHS Greater Glasgow FOI Steering Group would meet to review the operation of the Act within NHS Greater Glasgow and provide comment on the consultation by 31 March 2006.

If NHS Board Members would like to feed thoughts and comments into the consultation, Mr Hamilton welcomed these either via the questions template or directly to him whereby they could be included in the NHS Board's response. A copy of the full NHS Board response would be made available to Members in April 2006.

Head of Board Administration

Councillor Coleman raised concern at the public money being spent on the enforcement of the Act particularly with regard to staff time and resources. As such, he welcomed the review being undertaken since the Act's introduction.

Mrs Stewart welcomed the content of the report, the contents of which were very informative.

Mr McLaughlin asked what issues the NHS Board may wish to highlight in the consultation exercise. Mr Hamilton commented that it was likely the response would include concern about the tight 20 working day response timeframe, dealing with multiple requests and the fact that an applicant did not need to quote the Act when making a request – this made the capturing of statistics difficult.

In response to a question from Ms Dhir, Mr Hamilton confirmed that NHS Greater Glasgow had not charged for the provision of information within the first year of operation nor had NHS Greater Glasgow collated a detail of the costs incurred by it as an organisation in discharging the requirements under the Act.

DECIDED:

That the first annual monitoring report on the impact of the Freedom of Information (Scotland) Act 2002 for NHS Greater Glasgow be noted.

12. ANNUAL REVIEW 2005 – PROGRESS REPORT 2006/07

A report of the Director of Planning and Community Care [Board Paper No 06/07] asked the NHS Board to note the update since the Annual Review in August 2005.

The report provided an update on the actions agreed with the Scottish Executive as an outcome of NHS Greater Glasgow's Annual Review in August 2005. It covered:

ACTION BY

- Partnership Working
- Modernising Hospital Services
- Smoking Cessation
- Waiting Times
- Winter Planning
- Infection Control
- NHS Employment Contracts
- Efficiency

NOTED

13. WAITING TIMES

A report of the Chief Executive – South Glasgow University Hospitals Division and Acting Chief Executive – North Glasgow University Hospitals Division [Board Paper No 06/08] asked Members to note the progress made in meeting national waiting time targets.

Mr Calderwood began by recording his appreciation to all staff for their effort to meet the December 2005 target and, in particular, Jane Grant and Jonathan Best for helping to drive forward this work. Sir John echoed this sentiment.

Mr Calderwood pointed out that at the end of December 2005, there were no inpatients or day cases waiting over 26 weeks without availability status codes (ASCs). The 26 week maximum wait was, from January 2006, a national standard for service delivery. NHS Greater Glasgow failed to make its target in respect of outpatients with one patient waiting longer than 26 weeks for an outpatient appointment at 31 December 2005. This patient was seen at an outpatient clinic on 10 January 2006 and the incident highlighted some problems in the processing of referrals which had been reviewed and rectified.

Mr Calderwood emphasised that the scale of the challenge in Glasgow should not be underestimated. He put this in context by describing that at its peak, more than 25,000 outpatients were waiting longer than 26 weeks.

Mr McLaughlin asked about NHS Greater Glasgow's ability to sustain this position particularly given the comments in the recent Audit Scotland Report. Mr Divers responded by confirming that the capacity plans developed over the past two years had specifically shown what recurring and non-recurring monies were necessary to achieve these standards. Mr Divers had been disappointed with elements of the Audit Scotland Report as NHS Greater Glasgow had a systematic programme of building into the service the capacity and resources to sustain the improved standards after the new targets had been reached.

Mr Cleland asked if it would be possible to receive a more up to date insight into the waiting time figures (he noted that this report looked at the figures up to 31 December 2005). Mr Divers explained that it was his intention to present a more recent picture in future at the PRG meetings over and above bi-monthly consideration at NHS Board meetings.

NOTED

ACTION BY

14. FINANCE REPORT TO NOVEMBER 2005

A report of the Director of Finance [Board Paper No 06/9] asked the NHS Board to note the Finance Report to November 2005.

Mr Griffin commented that the outturn for the period to November 2005 showed overall expenditure exceeding available funding by £1.2m. This presented a very similar picture to that reported at the mid year point confirming that, in overall terms, the NHS Board was continuing to manage expenditure levels closely in line with the plan.

NOTED

15. EAST RENFREWSHIRE COMMUNITY HEALTH AND CARE PARTNERSHIP – STANDING ORDERS FOR APPROVAL

A report of the Head of Board Administration [Board Paper No 06/10] asked the NHS Board to approve, from 1 April 2006, the Standing Orders and Membership (to date) of the East Renfrewshire Community Health and Care Partnership Committee, subject to any minor drafting points to be agreed with the Council.

Ongoing discussions would continue with officers of the Council to bring to a conclusion some minor points of detail to be agreed over the next week. Similarly, the remaining Members of the CHCP would be worked through over the coming weeks with the appropriate nominating bodies to ensure that the CHCP Committee could operate from 1 April 2006.

The Head of Board Administration asked that the NHS Board consider increasing the Non-Executive Director representation from one to two to achieve a better balance of membership in the CHCP Committee.

DECIDED:

(i) That the Standing Orders and Membership (to date) of the East Renfrewshire Community Health and Care Partnership Committee, subject to any minor drafting points to be agreed with the Council, be approved. **Head of Board Administration**

(ii) That the Non-Executive Director representation from NHS Greater Glasgow be increased to two. **Head of Board Administration**

16. NEW MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF Section 22 APPROVED MEDICAL PRACTITIONERS

A report of the Acting Director of Public Health [Board Paper No 06/11] asked the NHS Board to approve the list of medical practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the New Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the three medical practitioners listed on the Board paper be approved for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003. **Acting Director of Public Health**

ACTION BY

17. PERFORMANCE REVIEW GROUP MINUTES

The Minutes of the Performance Review Group meeting held on 15 November 2005 [PRG(M)05/06] were noted

NOTED

18. SOUTH GLASGOW DIVISIONAL MANAGEMENT TEAM MINUTES

The Minutes of the South Glasgow Divisional Management Team meeting held on Wednesday 14 December 2005 [Board Paper No 06/12] were noted.

NOTED

19. GLASGOW CENTRE FOR POPULATION HEALTH MINUTES

The Minutes of the Glasgow Centre for Population Health Management Board [GCPHMB(M)05/6] meeting held on Thursday 20 October 2005 were noted.

NOTED

The meeting ended at 12 noon

NHSGG&C(M)06/2
Minutes: 20 - 43

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 18 April 2006 at 9.30 a.m.

P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Professor D Barlow
Councillor J Coleman
Councillor D Collins
Ms R Crocket
Mrs R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Councillor T Fyfe
Mr D Griffin
Mr P Hamilton
Councillor J Handibode
Mrs S Kuenssberg CBE
Ms G Leslie
Mr G McLaughlin
Mrs R K Nijjar
Ms A Paul
Mr A O Robertson OBE
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE

Councillor T Williams

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Dr L de Caestecker	..	Acting Director of Public Health
Mr J Crawford	..	Corporate Inequalities Manager – Race & Faith (for Minute 29)
Mr J C Hamilton	..	Head of Board Administration
Ms S Laughlin	..	Head of Inequalities and Health Improvement (for Minute 29)
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy (to Minute 26)
Mr D Walker	..	Head of Performance and Corporate Reporting

ACTION BY

20. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr J Bannon, Mr R Cleland, Dr B N Cowan, Dr R Groden, Mrs J Murray and Councillor A White.

The Chairman welcomed Councillor Fyfe and Councillor Williams, who were attending their first meeting of the NHS Board.

21. CHAIRMAN'S REPORT

i) The Chairman referred to the launch of the Glasgow Centre for Population Health Observatory Report – Let Glasgow Flourish which had been well covered within the local press. The Report identified a number of health challenges associated with alcohol, diabetes and obesity. These and other aspects of the Report required the collective focus and attention of the major stakeholders in health in order to tackle and bring about improvements.

ii) Sir John referred to the dissolution of NHS Argyll and Clyde on 31 March 2006 and the integration of the Local Authority areas of Renfrewshire, Inverclyde and the remaining parts of East Renfrewshire and West Dunbartonshire within the expanded boundary of NHS Greater Glasgow and Clyde. The Local Authority area of Argyll and Bute had transferred to NHS Highland. He recognised the significant amount of work associated with the dissolution of NHS Argyll and Clyde and integration within the two respective NHS Boards and asked that Members be kept appraised of the ongoing issues during the integration period.

iii) Sir John referred to the launch of the consultation on the New Children's Hospital where comments were sought by 2 June 2006 and to the public meeting to be held at 6.30 p.m. on 27 April 2006 at the Holiday Inn, Bothwell Street, Glasgow to hear people's views about the NHS Board's proposals.

iv) Sir John sought and received the NHS Board's approval to taking Agenda Item 12 – Scheme of Establishment for Renfrewshire Community Health Partnership immediately after Agenda Item 6 – Local Delivery Plan.

NOTED

22. CHIEF EXECUTIVE'S UPDATE

i) Picking up on Sir John's comments about the dissolution and integration of services from NHS Argyll and Clyde, Mr Divers advised that the Project Board overseeing this work was to hold its final meeting at the end of April 2006 and thereafter a Transition Plan under the direction of Ms Anne Hawkins, Project Director, would be taken forward, implemented and monitored by a Transition Group which he would chair.

ii) Mr Divers advised of the ongoing work with NHS Forth Valley and NHS Lanarkshire in connection with its consultation "Picture of Health" and his attendance at public meetings in connection with this consultation. He made reference to seven meetings which had been held, over recent months, with officials from NHS Lanarkshire and Forth Valley to discuss the impact of the proposals on services within NHS Greater Glasgow.

iii) Mr Divers referred to the meeting he and Sir John had held with Inverclyde Council in connection with the possibility of developing an integrated model of a Community Health Partnership for that area and would keep members advised of progress.

NOTED

23. MINUTES

On the motion of Mrs E Smith, seconded by Mr G McLaughlin, the Minutes of the meeting of the NHS Board held on Tuesday, 21 February 2006 [GGNHSB(M)06/1] were approved as an accurate record and signed by the Chairman.

24. MATTERS ARISING FROM THE MINUTES

The Matters Arising Rolling Action List was circulated and noted.

NOTED

ACTION BY

25. LOCAL DELIVERY PLAN

A report of the Director of Corporate Planning and Policy [Board Paper No. 06/13] was submitted advising that the Scottish Executive Health Department (SEHD) had contacted the NHS Board in order to address and resolve issues arising from the Local Delivery Plan with a view to these being formally signed off by the Chief Executive of NHS Scotland by the end of the month.

The approaches from the SEHD had focused primarily on either the trajectory for the target and/or the rigour of the risk assessment. As a consequence, a series of amendments highlighted in the paper had been made to the NHS Board's original Local Delivery Plan.

Ms Renfrew highlighted two specific targets:-

i) Out-patient waiting times – the SEHD asked that the original trajectory which predicted a rise in the number of waits during 2006 be re-considered and the Chief Executive Waiting Times Group had revised the trajectory which had now been accepted by the SEHD.

ii) Multiple emergency admissions – the SEHD was concerned that the trajectory undershot the 2008 target and following re-consideration of the NHS Board's position, the SEHD had been advised that the original trajectory remained and it had been appreciated that this would therefore be rated as a "fail" on this target. Further discussions would be held with the SEHD on this target.

Mr McLaughlin asked for further information in relation to the difficulty in meeting the SEHD's target on multiple emergency admissions. Ms Renfrew advised that when submitting the Local Delivery Plan, the NHS Board had the following concerns:

- lack of evidence around this target which could justify the level of reduction sought;
- the limited depth of understanding of the make-up of multiple admissions and therefore the potential to reduce these;
- the insufficient account taken of the effect of deprivation on multiple admissions;
- the lack of consideration of alternatives linked, for example, to length of stay or re-admission within 7 or 28 days.

It was intended to carry out further work to better understand the factors involved which impacted on this target and at the SEHD's request to continue dialogue on the NHS Board's position.

Sir John asked about the further work being undertaken on targets relating to cancer waiting times, diagnostics, A&E waiting times, cataracts, hip surgery and cardiac intervention/cardiac out-patient waits and whether Members could be advised of the trajectory for each. Ms Renfrew agreed to provide this information to Members outwith the meeting. **Director of Corporate Planning and Policy**

Arrangements had been put in place to allocate the local delivery targets to each of the main operational units of the NHS Board as part of the overall performance management framework and to establish supporting information systems and reporting disciplines to ensure that the proper processes were in place to ensure delivery of the promised performance against each target. Scrutiny of the Local Delivery Plan was due this summer and would feature as a significant part of the Annual Review meeting with the Minister for Health and Community Care.

ACTION BY

DECIDED:

1. That the SEHD's response to the NHS Board's Delivery Plan be noted.

2. That the NHS Board's proposed actions be approved. **Director of Corporate Planning and Policy**

3. That the NHS Board's internal implementation timescale as set out in Annex 2 of the paper, be noted.

26. SCHEME OF ESTABLISHMENT FOR RENFREWSHIRE COMMUNITY HEALTH PARTNERSHIP

A report of the Director of Corporate Planning and Policy [Board Paper No. 06/19] was submitted which set out the draft Scheme of Establishment for a Community Health Partnership (CHP) covering the Renfrewshire Council area. The proposed CHP brought into a single authority-wide structure the responsibilities for management of local health services and health improvement. At this stage, however, Renfrewshire Council did not wish to pursue the Board's preferred model of a fully integrated CHP. The Scheme was, however, a significant step forward in bringing together the co-ordination and management of services to a single population and achieving co-terminosity with the Renfrewshire Council area providing a basis to build, strengthen and extend joint working arrangements.

Renfrewshire Council had approved the draft Scheme of Establishment at its meeting on 16 March 2006.

Ms Renfrew drew attention to Section 3 which set out the governance arrangements and relationships and, in particular, the membership of the proposed CHP Committee. Attention was also drawn to Section 7 on the CHP's joint responsibilities with Renfrewshire Council and the range of services, staff and budgets which this would cover. These arrangements would replace current structures with the Council and lead to closer working and management arrangements for the benefit of patients and the community. Councillor Williams advised that he appreciated the flexibility being offered in the discussions with the NHS Board and believed that the CHP, once established, would evolve. He believed that a review at a later date was likely to have included the option of moving to an integrated set of arrangements. He thanked NHS Board officers for their time and effort in developing the CHP arrangements for the Renfrewshire Council area.

Mrs Dhir asked if there would be a timeline towards an integrated CHP and the criteria around the review process. Ms Renfrew advised that it would be important to allow the CHP to develop and evolve through time and the CHP Committee would be best placed to advise the NHS Board on any next stages of development. The performance management framework for CHPs would result in regular reporting back in to the NHS Board on a range of issues. This led Councillor Collins to suggest that there may be some advantage later in the autumn to consider at an NHS Board Seminar the common issues and learning points for CHCPs/CHPs to ensure that good practice was being shared in the most appropriate way.

Sir John welcomed this idea and asked that it be included in the list of topics for NHS Board Seminars later on in the year. **Director of Corporate Planning and Policy**

ACTION BY

DECIDED:

1. That the Scheme of Establishment for the Renfrewshire Community Health Partnership (covering the Renfrewshire Council area) be approved. **Director of Corporate Planning and Policy**

2. That the next steps in developing the Community Health Partnership be noted.

27. PROPOSED CAPITAL PLAN: 2006/07 – 2007/2008

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No. 06/14] was submitted setting out proposals for the allocation of available capital resources for 2006/07 and described the capital planning process to be followed from 1 April 2006. Ms Byrne introduced the paper and highlighted that the allocation of the capital funds covered the NHS Greater Glasgow area only and that a subsequent paper would be developed for the "Clyde" area shortly.

The NHS Board had received confirmation of its allocation of capital funds from SEHD for 2006/07 and 2007/08. The 2006/07 figure of £119.823m took account of funding carried forward from the 2005/06 capital allocation and the funds made available to carry out the development of the new Beatson Oncology Centre at Gartnavel General Hospital. The 2007/08 capital allocation amounted to £87.894m.

In addition, the SEHD had announced that a further £8.3m of capital funding would be made available spread over 2006/07 and 2007/08 to fund projects at Springburn Health Centre, Drumchapel Integrated Child and Family Centre and Partick Centre for Community Health Phase II. There had also been the previous Ministerial announcement of £100m of capital funding being made available to fund the new Children's Hospital. Planning of this facility was under way and when the phasing of the capital expenditure was confirmed the Capital Plan would be updated accordingly.

Ms Byrne took Members through the review of the current Capital Plan and the proposals for the allocation of capital resources. She described the setting up of the Capital Planning Group which would be responsible for development and maintenance of the NHS Board's Capital Plan.

Mrs Dhir asked about the timescale and process for developing the Capital Plan for the "Clyde" area. Ms Byrne advised that there was a detailed analysis currently under way of the Capital Plan and, while she may be in a position to give an update to the Performance Review Group in May, it may be a few months' time before a detailed plan could be worked up and considered by the Planning Group prior to submission to the NHS Board. Priorities would need to be better understood and the review of schemes would need to look at the short and long term impact.

DECIDED:

1. That the proposed allocation of capital funds for NHS Greater Glasgow for 2006/07 be approved. **Director of Acute Services Strategy,**

2. That the proposed allocation of capital funds for 2007/08 be noted. **Implementation & Policy**

3. That the intention that the Chief Executive be granted delegated authority to allocate the residue of available capital funds in 2006/07 be approved. **Chief Executive**

4. That the capital planning process for 2006/07 be noted.

ACTION BY

28. WORKFORCE PLAN 2006

A report of the Director of Human Resources [Board Paper No. 06/15] was submitted setting out the progress on the development of the Workforce Plan and seeking approval to the associated Action Plan.

Mr Reid advised that the NHS Greater Glasgow Workforce Plan 2006 was currently being developed and consulted upon – this had been part of a national, regional and local framework of workforce planning activity introduced in NHS Scotland last year.

The first West of Scotland Workforce Plan was published in January 2006: a further West of Scotland Workforce Plan would be published in September 2006 and a national Workforce Plan in December 2006. From 2007 onwards NHS Board Workforce Plans would be published in April with the West of Scotland Workforce Plan in September and the national Workforce Plan in December.

The Workforce Plan linked to the Local Delivery Plan and was a high level overview of detailed workforce planning activity covering both service areas – children's services, mental health, learning difficulties, primary care and individual professions – nursing & midwifery, allied health professionals. The Workforce Plan had been prepared in parallel with the NHS Argyll and Clyde Plan and the Action Plans were identical in that they identified a direction of travel designed to cover the next five years.

Mrs Dhir asked if the change in employment legislation about age discrimination had been considered as it opened up the possibility of a wider range of workers. Mr Reid advised that this would require some amendment to the superannuation scheme and that he would take this point on board for further discussions in developing the Workforce Plan. **Director of Human Resources**

Mr McLaughlin sought comment on the possible impact of the enlarged European Union and, while Mr Reid did acknowledge that a wider range of markets had been used in the past, this was a further new area to be considered in the future.

Councillor Collins asked about the range of groups who were involved and the need to increase the involvement of Local Authorities, particularly now that Community Health Care Partnerships had been established. Mr Reid agreed to map out the different groups across NHS Greater Glasgow and Clyde and make this available to Members. **Director of Human Resources**

Mrs Smith raised the Pathfinders Project and was pleased to see that this had been linked in within the Workforce Plan – under the Efficient Government Initiative. There was a requirement to maximise shared services within health and then see whether this could be achieved with Local Authorities. The integrated Community and Health Care Partnership models had been very helpful in this area.

DECIDED:

1. That the progress on the development of the Workforce Plan be noted.

2. That the associated Action Plan be approved. **Director of Human Resources**

29. REPORTING ON EQUALITY LEGISLATION

A report of the Head of Inequalities and Health Improvement [Board Paper No. 06/16] was submitted seeking approval to the Race Equality Action Plan 2002/2005 and the Race Equality Scheme for 2005/2008.

Ms Sue Laughlin, Head of Inequalities and Health Improvement, and Mr John Crawford, Corporate Inequalities Manager – Race & Faith, attended to introduce both reports.

The report on Race Equality Action 2002/2005 satisfied the requirements of the Race Relations (Amendment) Act 2002 in that all public bodies were required to publish a Race Equality Scheme and thereafter publish a report based on the progress achieved from actions identified within that scheme.

The Race Equality Scheme 2005/2008 set out the future actions for NHS Greater Glasgow and Clyde based on the further development of and consultation on the report on Race Equality Action Plan. Following the integration of "Clyde" there would be further work to refine the 2005/2008 Race Equality Scheme.

Ms Laughlin advised that the approach taken had been designed to ensure that there was sufficient local ownership and commitment to race equality and that each part of the organisation within the NHS Board had carried out an analysis of their functions and compiled a Race Equality Action Plan specific to their own circumstances.

There were, however, a number of strategic issues which were best tackled on an NHS Board-wide basis, namely:-

- Interpreting
- Advocacy
- Training
- Employment
- Research
- Information
- Communication
- Involving People
- Looking/listening to communities
- Catering
- Complaints
- Procurements

Each was covered in the Race Equality Action Plan together with the progress achieved.

A meeting with the black and minority ethnic communities, facilitated by the West of Scotland Race Equality Council, had been held to receive their feedback on the progress against the identified actions.

In the new re-structured NHS Greater Glasgow and Clyde, there had been established a Corporate Inequalities Team which had responsibilities to support the organisation in complying with the current and forthcoming equalities legislation requirements and in developing a systematic and co-ordinated approach to reducing inequalities in health. Mr Crawford advised that from 2006 there would be a Race Equality Duty, a Disability Equality Duty and a Gender Equality Duty placing legal responsibilities on public sector organisations to produce race, gender and disability equality schemes. Ms Laughlin indicated that eventually there would be a need for a harmonised approach which draws all the schemes together under one Equality Scheme.

ACTION BY

Sir John asked about the data collection mechanisms in place around the areas covered within the Race Equality Schemes – Mr Crawford advised that a Scotland-wide system was still being developed and therefore local arrangements would continue to be in place for the time being.

Mrs Nijjar enquired as to what health needs assessments had taken place and Mr Crawford advised that he would provide this information separately once he had accessed the detail from colleagues. **Corporate Inequalities Manager – Race & Faith**

Mr Crawford commented that relationships with the different communities were variable. Ms Laughlin advised that it would be the intention to bring inequalities in to the main stream of the NHS Board's work and that the Corporate Inequalities Team would support all aspects of the NHS Board's responsibilities to ensure the inequalities agenda was embedded into the work of the NHS Board and its staff.

Mrs Dhir commended the work undertaken and advised that she had chaired the initial Working Group looking at inequalities and she had been impressed at just how much this agenda had moved forward and was receiving real commitment from the NHS Board. On the issue of procurement and how to influence the companies which do business with the NHS Board, it was acknowledged that the recent receipt of the SEHD guidance would allow the NHS Board greater opportunities to negotiate with suppliers to ensure that they followed good practice in implementing inequalities policies.

Mr McLaughlin, while acknowledging the significant progress achieved, wondered what other learning opportunities were available in NHS Scotland or the UK which could influence best practice within the NHS Board area. This point was acknowledged and the links with the National Resource Centre for Ethnic Minority Health had been useful in developing the Race Equality Schemes and Action Plans. Other learning opportunities from good practice would certainly be considered where applicable.

DECIDED:

1. That the Race Equality Action Report 2002/2005 be approved. **Head of Inequalities and Health Improvement**

2. That the Race Equality Scheme 2005/2008, recognising further work was still required to encompass the Clyde element of the expanded organisation, be endorsed.

3. That the role of the newly established Corporate Inequalities Team to assist in complying with the current and future equality legislation, be noted.

30. FINANCIAL GOVERNANCE MATTERS

A report of the Director of Finance – Corporate and Partnerships [Board Paper No. 06/17] was submitted setting out the process under way to update Standing Financial Instructions (SFIs) and associated documents in tandem with the implementation of the new organisational structure and seeking approval to an interim list of authorised signatories for signing consequential contracts and health care agreements.

ACTION BY

Mr Griffin introduced the paper by advising that a programme of work was approved by the Audit Committee which would see the review of Standing Financial Instructions and associated documents completed by 30 June 2006, thereafter to be considered by the Audit Committee and then submitted to the NHS Board for approval. A series of navigational aids for staff in CHCPs and CHPs to assist in complying with SFIs of both the NHS Board and the relevant Local Authority were being developed.

Standing Financial Instructions required the NHS Board to approve a list of officers with the authority to sign agreements for the purchase or provision of health care and related contracts.

DECIDED:

1. That the interim Schedule of Authorised Signatories for Health Care Agreements and related Contracts (and the arrangements for amending this Schedule) be approved. **Director of Finance**

2. That the process for revising the financial governance arrangements which supported the new organisational structure be noted.

31. DESIGNATED MEDICAL OFFICERS

A report of the Acting Director of Public Health [Board Paper No. 06/28] was submitted setting out the arrangement under current legislation for Designating Medical Officers for the purposes of exercising such functions on behalf of Local Authorities as may be assigned by or under enactment and other such functions as Local Authorities may assign with the agreement of the Board.

Following integration with the "Clyde" part of the former NHS Argyll and Clyde Health Board it was necessary to merge the lists of the Designated Medical Officers from both Boards and seek approval to the merged list.

DECIDED:

That the list of Designated Medical Officers in accordance with the regulations laid out in the NHS (Scotland) Act 1978 and the NHS (Designated Medical Officers) (Scotland) Regulations 1974 be approved. **Acting Director of Public Health**

32. QUARTERLY REPORT ON COMPLAINTS: OCTOBER – DECEMBER 2005

A report of the Head of Board Administration, Chief Operating Officer, Acute and Lead Director, CHCP (Glasgow) [Board Paper No. 06/20] was submitted setting out the routine Quarterly Report on Complaints Handling within NHS Greater Glasgow for the period October – December 2005.

ACTION BY

It was reported that discussions had been held with clinical governance colleagues to establish a more formal arrangement to ensure organisational learning from complaints with a link into clinical governance arrangements. This had been one of the themes at the Complaints – Symposium and Solutions: Using Grievances to Inform Governance - Conference on 17 March 2006 which had been hosted by the Scottish Public Sector Services Ombudsman and NHS Scotland – Chief Executive. It was recognised that the Clinical Governance Committees had a role in monitoring the number and types of complaints and should be required to take a role in completing the audit loop of ensuring that lessons were learned from complaints and that action had been taken to prevent any repeat occurrences.

It was also reported that the Scottish Executive had launched HDL(2006)13 – Patient Focus and Public Involvement – Independent Advice and Support Service to Complaints. This required NHS Boards to fund the implementation of a service locally through a strategic partnership with a consortium of Citizens Advice Bureaux with the intention that the service be established and operational during the course of 2006.

Councillor Williams asked about the handling of verbal complaints and whether they were captured within the analysis submitted in the Quarterly Complaints Report. Mr Hamilton advised that verbal complaints were not registered and reported routinely to the NHS Board as many were dealt with at a local level within wards and clinics and were very seldom recorded in such a way that they could be reported in a meaningful way.

Mrs Kuenssberg asked about the evaluation and satisfaction mechanisms associated with the role to be undertaken by the Citizens Advice Bureau (CAB) in providing independent advice and support to complainants. It was reported that the Scottish Health Council would be monitoring the arrangements to ensure overall compliance with the principles of the framework and whether the CABs were supporting complainants in the manner intended.

Councillor Williams asked about what was known about the satisfaction rate from patients accessing the NHS services and whether this was formally recorded. National surveys had indicated that there was normally a 85% public satisfaction with the services, however, Mr Divers advised that it was important to look and find local mechanisms to sample satisfaction and some suggestions had been provided at the recent Complaints Seminar which the Head of Board Administration and colleagues would pursue in order that a more rounded feedback could be provided to the NHS Board on this matter.

Head of Board Administration

DECIDED:

That the Quarterly Report on NHS Complaints in NHS Greater Glasgow for the period 1 October to 31 December 2005 be noted.

33. WAITING TIMES

A report of the Chief Operating Officer – Acute Division and Director of Surgery & Anaesthetics - Acute Division [Board Paper No. 05/21] asked Members to note the progress made in meeting national waiting time targets.

Mr Calderwood advised that the Waiting Times Report was based on NHS Greater Glasgow information up to 31 March 2006 and steps were being taken to define how future reporting would be considered on the new targets and on the "Clyde" element for dissolution of NHS Argyll and Clyde.

ACTION BY

It had been important to sustain the delivery of all national standards/guarantees during the first quarter of 2005/06. This was achieved and the target of delivering a maximum of 1,000 in-patient/day cases (non availability status codes) waiting longer than 18 weeks by 31 March was delivered in that 795 patients were waiting over 18 weeks as at the end of March which was 21% better than the planned position.

With regard to plans for 2006/07 the following had been agreed:-

i) Planning milestones with the National Waiting Times Unit for sustained reduction in under 18-week waits for in-patient/day cases from the current level to zero by December 2006.

ii) Plans had previously been submitted to the National Waiting Time Unit for the abolition of Availability Status Codes and these were currently being reviewed as one of the main priority areas for improving waiting times during 2006/07.

Mrs Smith asked about Availability Status Code – 8 – where the patient did not attend or give any prior warning and indicated that this had stubbornly remained at about 15% for many years. Mr Divers spoke about the steps being taken to make proactive contact with patients prior to appointment: agree dates with patients six weeks ahead of treatment and consideration would certainly be given to a role that may include NHS 24 contacting patients prior to their appointment.

Sir John intimated that he was pleased with the steady progress being made with regard to waiting time and he was aware that detailed plans had been prepared which were underpinned by capacity planning which ensured the sustainability of the waiting time targets. The move to a single specialty structure within the Acute Services Division had been very helpful in focusing effort within specialties across sites.

NOTED

34. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Acting Director of Public Health [Board Paper No. 06/22] asked the NHS Board to approve the list of medical practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the New Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the four medical practitioners listed on the Board paper be approved for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

Acting Director of Public Health

35. PERFORMANCE REVIEW GROUP MINUTES: 24 JANUARY 2006 AND 21 MARCH 2006

The Minutes of the Performance Review Group meetings held on 24 January 2006 [PRG(M)06/01] and 21 March 2006 {PRG(M)06/02] were noted.

NOTED

36. INVOLVING PEOPLE COMMITTEE MINUTES: 10 JANUARY 2006

The Minutes of the Involving People Committee meeting held on 10 January 2006 [Board Paper No. 06/23] were noted.

NOTED

37. HEALTH AND CLINICAL GOVERNANCE COMMITTEE MINUTES: 2 MARCH 2006

The Minutes of the Health and Clinical Governance Committee meeting held on 2 March 2006 [HCGC(M)06/1] were noted.

NOTED

38. RESEARCH ETHICS GOVERNANCE COMMITTEE MINUTES: 25 JANUARY 2006

The Minutes of the Research Ethics Governance Committee meeting held on 25 January 2006 [NHSGGREGC(M)06/1] were noted.

NOTED

39. STAFF GOVERNANCE COMMITTEE MINUTES: 6 MARCH 2006

The Minutes of the Staff Governance Committee meeting held on 6 March 2006 [NHSGGSGC(M)06/1] were noted.

NOTED

40. AUDIT COMMITTEE MINUTES: 31 JANUARY 2006 AND 14 MARCH 2006

The Minutes of the Audit Committee meetings held on 31 January 2006 [A(M)06/1] and 14 March 2006 [A(M)06/2] were noted.

NOTED

41. AREA CLINICAL FORUM MINUTES: 16 MARCH 2006

The Minutes of the Area Clinical Forum meeting held on 16 March 2006 [ACF(M)06/2] were noted.

NOTED

42. PHARMACY PRACTICES COMMITTEE MINUTES: 13 FEBRUARY 2006

The Minutes of the Pharmacy Practices Committee meeting held on 13 February 2006 [Paper No. 06/24] were noted.

NOTED

ACTION BY

43. GLASGOW CENTRE FOR POPULATION HEALTH MINUTES: 1 MARCH 2006

The Minutes of the Glasgow Centre for Population Health meeting held on 1 March 2006 [GCPHMB(M)06/7] were noted.

NOTED

The meeting ended at 11.40 a.m.

NHSGG&C(M)06/3
Minutes: 44 - 76

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 27 June 2006 at 10.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Professor D Barlow
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B N Cowan
Ms R Crocket
Mrs R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Councillor T Fyfe
Mr D Griffin
Dr R Groden
Mrs S Kuenssberg CBE
Ms G Leslie
Ms J Murray
Mrs R K Nijjar
Mr A O Robertson OBE (to Minute 59)
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE
Councillor A White
Councillor T Williams

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

Ms L Bradley	..	Audit Scotland (to Minute No 56)
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mr N McGrogan	..	Head of Community Engagement
Mr A McLaws	..	Director of Corporate Communications
Mr C Revie	..	PricewaterhouseCoopers (to Minute No 56)
Mr I Reid	..	Director of Human Resources
Mr M White	..	PricewaterhouseCoopers (to Minute No 56)
Mr N Zappia	..	Head of Primary Care Support (for Minute No 76)

ACTION BY

44. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr J Bannon, Councillor J Coleman, Councillor J Handibode, Mr G McLaughlin, Ms A Paul, Mr P Hamilton, Ms C Renfrew and Dr L de Caestecker.

The Chairman welcomed Mr C Revie and Mr M White from PricewaterhouseCoopers and Ms L Bradley from Audit Scotland.

45. CHAIRMAN'S REPORT

(i) The Chairman congratulated Mr Divers on receipt of his honorary doctorate from the University of Glasgow.

ACTION BY

(ii) The NHS Board's Annual Review meeting with the Minister of Health and Community Care would be held on 22 August 2006. The format, location and timings of the event would be announced shortly.

(iii) The Chairman asked Mr Cleland to update the Board on developments to progress the new West of Scotland Regional Heart and Lung Centre at the Golden Jubilee National Hospital. Mr Cleland reported that a public meeting had been held on Monday 26 June 2006 to update on the progress made and raise awareness. There had been a turn out of around eighty people and presentations had concentrated on transport, accommodation and service developments. This was followed by a question and answer session and a tour around the new unit. It was anticipated that there would be one further session in the future to provide another update. The feedback had been positive and most agreed very informative.

(iv) The Chairman reported that interviews had been held for the Non-Executive Member positions from the Clyde area. Recommendations had been made to the Minister for Health and Community Care and it was anticipated an announcement would be made shortly.

NOTED

46. REPORT FROM THE VICE CHAIRMAN

Mr Robertson congratulated Sir John on the extension to his Chairmanship of the NHS Board for another year. He had been asked by the Minister for Health and Community Care to remain in office until 30 November 2007. Sir John was delighted to extend his Chairmanship and looked forward to another year helping to guide NHS Greater Glasgow and Clyde through its modernisation plan.

NOTED

47. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers had attended the third national seminar on Child Protection. This had been fruitful and resulted in significant outcomes in connection with affording greater recognition and cohesion amongst the various directorates and agencies involved in progressing the child protection agenda.

(ii) Mr Divers advised that he and others from the NHS Board had participated in a major emergency planning exercise (Operation Cutty Sark) which had been set up to test organisational plans in the event of a terrorist attack. This had been an excellent learning experience over two and half days and had tested each agency's approach and handling of an emergency situation. He thanked all those officers who had participated in the event from NHS Greater Glasgow and Clyde and noted the lessons learned from the debrief session.

(iii) Ongoing work continued with neighbouring NHS Boards, including NHS Lanarkshire and NHS Forth Valley in respect of affordability of key service strategies and assumptions as well as forward financial plans. This provided an excellent platform for the respective Chief Executives to work together and develop plans jointly recognising ongoing developments within each other's area.

(iv) Ongoing dialogues were taking place with Renfrewshire and Inverclyde Councils in respect of establishing their Community Health Partnerships and strategic priorities.

NOTED

ACTION BY

48. MINUTES

On the motion of Mrs A Stewart, seconded by Mrs E Smith, the Minutes of the meeting of the NHS Board held on Tuesday, 18 April 2006 [GGCNHSB(M)06/2] were approved as an accurate record and signed by the Chairman.

49. MATTERS ARISING FROM THE MINUTES

The Matters Arising Rolling Action List was circulated and noted.

NOTED

50. AUDIT COMMITTEE MINUTES – 20 JUNE 2006

The Audit Committee meeting Minutes from 20 June 2006 [A(M)06/4] were noted.

NOTED

51. STATEMENT ON INTERNAL CONTROL 2005/2006 – NHS GREATER GLASGOW

A report of the Convener of the Audit Committee [Board Paper No 06/26] was submitted attaching a report by the Audit Committee on the outcome of the Committee's evaluation of the NHS Board's system of internal financial control during 2005/2006.

Subject to approval of the report, the NHS Board was asked to authorise the Chief Executive to sign the Statement on Internal Control 2005/2006 which formed part of the NHS Board's Annual Accounts.

The Convener of the Audit Committee, Mrs E Smith, presented the report.

The Audit Committee, at its meeting held on 20 June 2006, received a report which provided Members with evidence to allow the Committee to review the NHS Board's system on internal control for 2005/2006. This represented the NHS Board's strategic pan-Glasgow role together with the operational activity to support this strategic role.

Based on the review of internal control, the Audit Committee approved, at its meeting on 20 June 2006, both a Statement of Assurance to the NHS Board on the system of internal control within NHS Greater Glasgow and a Statement on Internal Control for NHS Greater Glasgow.

Mrs Smith led the NHS Board through both Appendix 1 (Statement of Assurance by NHS Greater Glasgow Audit Committee in respect of the system of internal control within NHS Greater Glasgow) and Appendix 2 (Statement on Internal Control) and highlighted the following:

- There were no significant matters relating to the systems of internal control within NHS Greater Glasgow which required to be disclosed in the Statement on Internal Control.

ACTION BY

- The Audit Committee recommended that the NHS Board should approve the Statement on Internal Control and that the Statement on Internal Control be signed by the Chief Executive.

- Risk management and internal control were considered by the NHS Board and the NHS Greater Glasgow Audit Committee and were incorporated into the corporate planning and decision making processes of the NHS Board.

- A Committee structure had been established to ensure that all aspects of risk relating to the Board's activities were addressed and a Risk Management Strategy for NHS Greater Glasgow was approved by the NHS Board in March 2005.

- It was appropriate that the Statement on Internal Control should refer to the issue arising from the work of NHSScotland Counter Fraud Services in respect of the potential level of incorrect claims at the point of delivery for exemption from NHS prescription, dental and ophthalmic charges.

Sir John thanked Mrs Smith and Members of the Audit Committee for their valued work throughout the year. Mrs Smith thanked NHS Greater Glasgow's finance teams, Audit Committee Members and the internal and external auditors – all of whom had worked very hard throughout the year to reach this point.

DECIDED:

- That the Statement of Assurance from the Audit Committee be considered.

- That the Statement on Internal Control be approved for signature by the Chief Executive. **Chief Executive**

52. EXTERNAL AUDIT – ANNUAL REPORT TO BOARD MEMBERS – 2005/06 – NHS GREATER GLASGOW

A report of the External Auditors, PricewaterhouseCoopers [Board Paper No 06/27] was submitted enclosing the final report to NHS Board Members in respect of the Statutory Audit of the Annual Accounts for 2005/06.

Mr Revie from PricewaterhouseCoopers presented the external auditors' final report to NHS Board Members on the year ending 31 March 2006.

The Annual Report was issued as an element of the Statutory Audit of the NHS Board's Statement of Accounts for 2005/06. It was primarily designed to direct Members' attention to matters of significance that had arisen out of the audit process and to confirm the action planned by management to address the more significant matters identified for improvement.

The matters dealt with in the final report were identified by PricewaterhouseCoopers during its conduct of its normal audit procedures which were carried out in accordance with the framework and principles embodied within the Code of Audit Practice.

Mr Revie led the NHS Board through the final Audit Report and highlighted the following:

- The true and fair opinion of the Financial Statements was unqualified.

- The regularity opinion on income and expenditure was unqualified but drew attention to patient exemptions with regard to pharmacy, dental and ophthalmic charges.

- The Counter Fraud Services (CFS) of National Services Scotland performed testing in relation to patient exemptions with regard to pharmacy, dental and ophthalmic charges for the whole of Scotland. On the basis of the data obtained, the CFS extrapolated the information to give an estimated total value for patient exemptions that may be non-eligible. The extrapolation for NHS Greater Glasgow (now NHS Greater Glasgow and Clyde) for 2005/06 suggested that exemptions amounting to £7.2M may have been given that were not eligible. As a result of the work by the CFS and the potential control deficiencies which may exist, the NHS Board had outlined this matter concerning patient exemptions in its Statement of Internal Control and Directors' Report.

- The NHS Board had achieved its three financial targets of:

    - The net resource limit did not exceed the revenue resource limit – the NHS Board spent £1,358M against its revenue resource limit of £1,370.3M, resulting in a surplus of £12.3M.

    - Staying within its capital resource limit – the NHS Board spent £69.337M against its capital resource limit of £69.460M.

    - The NHS Board did not exceed its cash requirement target – the NHS spent £1,323M against a limit of £1,323M.

Mr Revie summarised the audit process and accounting issues and highlighted the following:

- A Glasgow-wide integrated operational financial service (OFS) had been established and faced a number of challenges.

- A key task was to merge Divisional ledgers – good progress had been made but the new ledger structure was complex.

- In year visits identified concerns of controls and processes – these had been reported to the Audit Committee and an action plan had been established by OFS management.

- The final visit in May 2006 revealed tangible improvements although bank account reconciliations required continued attention.

- Various audit adjustments were agreed with management and all were amended in the final Annual Accounts.

In respect of other governance matters, Mr Revie briefly discussed the NHS Board's four key governance responsibilities in respect of the NHS Board and the formation of Community Health Partnerships, namely, financial and performance governance, clinical governance, risk management and staff governance.

ACTION BY

In respect of performance management, the NHS Board had a Local Delivery Plan which had twenty-eight targets, informed by thirty-two key measures distributed across four objectives. The Local Delivery Plan was supported by a five-year financial plan and a revised performance management framework was being implemented through each of the NHS Board's new Operating Units. Attention was being devoted to the challenge of meeting the maximum eighteen week waiting time target by December 2006.

Mr Revie highlighted the action plan at Appendix 1 which he confirmed was complete, included named responsibilities and timescales for completion.

Mr Divers was confident that the NHS Board would deliver its key targets for 2006/07. He confirmed that discussions were ongoing with the Scottish Executive Health Department regarding the transition process of Clyde. It had been agreed that the NHS Board would manage financial balance over a period of three years. This allowed time to get to know the organisation itself and to develop a detailed financial recovery plan.

Sir John thanked staff within the Finance Directorate for their assistance throughout the annual accounts and audit processes – likewise, Mr Revie thanked all NHS Greater Glasgow staff who had co-operated throughout their audit investigation.

DECIDED:

That the final report to NHS Board Members from the NHS Board's external auditors, PricewaterhouseCoopers, in respect of the Statutory Audit of Annual Accounts for 2005/06 be noted.

53. STATEMENT OF ACCOUNTS FOR 2005/06 – NHS GREATER GLASGOW

A report of the Director of Finance [Board Paper No 06/28] was submitted enclosing the Statement of Accounts for the year to 31 March 2006.

Mr Griffin introduced the accounts which had previously been considered by the Audit Committee. The external auditors had completed their audit of the accounts and had issued their final report to the NHS Board Members which confirmed that their audit certificate on the NHS Board's financial statement for the year ended 31 March 2006 would be unqualified in respect of their true and fair opinion and regularity.

Mr Griffin confirmed that the NHS Board's Financial Statement disclosed that the NHS Board had met its financial targets.

In commending the accounts for approval, Mr Griffin recorded his appreciation of the considerable efforts of all members of staff who had contributed to the financial year outcome and also to the external auditors for their assistance and forbearance.

Sir John endorsed these sentiments. He thanked Mr Revie and his colleagues for their work throughout the period for which they had served as External Auditors to the Board. Mr Revie thanked Mr Griffin and his staff for the helpful and productive way they assisted the external auditors in their role.

DECIDED:

- That the Statement of Accounts for the financial year ended 31 March 2006 be adopted and approved for submission to the Scottish Executive Health Department. **Director of Finance**

ACTION BY

- That the Chief Executive be authorised to sign the Directors' Report. **Chief Executive**

- That the Chairman and Director of Finance be authorised to sign the Statement of Health Board Members' responsibilities in respect of the accounts. **Chairman/ Director of Finance**

- That the Chief Executive be authorised to sign the Statement on Internal Control in respect of the accounts. **Chief Executive**

- That the Chief Executive and Director of Finance be authorised to sign the balance sheet. **Chief Executive/ Director of Finance**

54. EXTERNAL AUDIT – ANNUAL REPORT TO BOARD MEMBERS – 2005/06 – NHS ARGYLL AND CLYDE

A report of the external Auditors, Audit Scotland [Board Paper No 06/29] was submitted enclosing the final report to NHS Board Members in respect of the Statutory Audit of the Annual Accounts for 2005/06.

Ms Bradley from Audit Scotland presented the external auditors' final report to NHS Board Members on the year ending 31 March 2006.

At the outset, Ms Bradley thanked Mr J Hobson and his team from NHS Argyll and Clyde for their co-operation throughout the audit process. She confirmed that Audit Scotland had carried out its work in the context of dissolution of NHS Argyll and Clyde and this was reflected in their final report. She led the NHS Board through three broad areas, namely, dissolution and integration, financial position and the audit report.

In respect of dissolution and integration, Ms Bradley highlighted the following:

- This represented a major impact on the risks facing NHS Argyll and Clyde and on its operations – both to keep the day-to-day business going as well as to deliver service change.

- New structures and processes were developed in collaboration with NHS Highland and NHS Greater Glasgow and a Dissolution and Integration Project Board and a Dissolution and Integration Project Team was established.

- A new risk management structure was put in place strengthened by the appointment of an external project manager.

- Senior staff left the organisation and were not replaced, putting pressure on remaining staff and risk management processes.

- Despite the change and loss of staff, NHS Argyll and Clyde did meet waiting time targets, budget targets and from a patient's perspective it was business as usual. They also made good progress with their staff governance plans.

Ms Bradley advised that NHS Argyll and Clyde had a cumulative deficit of £81.7M. The Scottish Executive Health Department had provided £82.3M leaving the NHS Board with a surplus of £600,000 which would transfer to NHS Greater Glasgow and NHS Highland.

Audit Scotland was aware that NHS Greater Glasgow and Clyde was developing an alternative financial recovery plan recognising that the 2005/06 recurring funding gap of £28.4M had been transferred to the successor Boards and most of this specifically to NHS Greater Glasgow and Clyde.

Ms Bradley summarised the action plan from the audit processes and focussed on areas which had future implications for the successor Boards as follows:

- NHS Argyll and Clyde had no strategy in place to develop acute services to meet the requirements of Delivering for Health.

- There was a risk that the expected savings within the original plan would not be delivered because of a delay in implementing the clinical services strategy.

- CHPs were not implemented, creating a risk that the population in this area would not benefit from service development to the same extent as the rest of the NHS Board's population.

- NHS Argyll and Clyde did not implement the best value guidance and so this would be an area for successor Boards to address.

- A disaster recovery plan was not in place for IT systems.

Although the auditor's report included an explanatory paragraph on the dissolution, this was not a qualification. The report stated that the statements gave a true and fair view and had been properly prepared. It also stated that in all material respects, the expenditure and income had been incurred in accordance with the applicable laws and guidance.

Mr Divers made three points in response to the comments made on the NHS Argyll and Clyde deficit and the development of a recovery plan to address this.

- NHS Argyll and Clyde did not have in place comprehensive clinical strategies which had been approved by the Minister for either acute and non-acute services. Accordingly, there was as yet no approved plan for taking forward service change on which a financial savings plan could be based.

- The cost savings plan prepared by the former NHS Argyll and Clyde had been analysed in some detail by officers from NHS Greater Glasgow and NHS Highland. This examination had confirmed that the plan was not sufficiently developed to deliver more than a fraction of the targeted savings, reflecting the fact that service change plans had yet to be developed.

- Useful discussions had taken place with colleagues in Renfrewshire and Inverclyde Councils which would allow rapid progress to be made in taking forward plans to establish CHPs within these areas.

Sir John referred to the challenge that lay ahead but highlighted the many areas of work that had been achieved so far particularly given that there had been continuity of business and joint working with partners.

- **DECIDED:**

That the final report to NHS Board Members from the Board's External Auditors, Audit Scotland, in respect of the Statutory Audit of Annual Accounts for 2005/06 be noted.

ACTION BY

55. STATEMENT OF ANNUAL ACCOUNTS – 2005/06 – NHS ARGYLL AND CLYDE

A report of the Director of Finance [Board Paper No 06/30] was submitted enclosing the Statement of Accounts for the year to 31 March 2006.

Mr Griffin introduced the accounts which had previously been considered by the Audit Committee. The external auditors had completed their audit of the accounts and had issued their final report to the NHS Board Members which confirmed that their audit certificate on the NHS Board's financial statement for the year ended 31 March 2006 would be unqualified in respect of their true and fair opinion and regularity.

Mr Griffin confirmed that the NHS Board's Financial Statement disclosed that the NHS Board had met its financial targets.

In commending the accounts for approval, Mr Griffin recorded his appreciation of the considerable efforts of all members of staff who had contributed to the financial year outcome and also to the external auditors for their assistance and forbearance.

Sir John endorsed these sentiments and thanked all staff for the helpful and productive way they assisted the external auditors in their role.

DECIDED:

- That the Statement of Accounts for the financial year ended 31 March 2006 be adopted and approved for submission to the Scottish Executive Health Department. **Director of Finance**
- That the Chief Executive be authorised to sign the Directors' Report. **Chief Executive**
- That the Chairman and Director of Finance be authorised to sign the Statement of Health Board Members' responsibilities in respect of the accounts. **Chairman/ Director of Finance**
- That the Chief Executive be authorised to sign the Statement on Internal Control in respect of the accounts. **Chief Executive**
- That the Chief Executive and Director of Finance be authorised to sign the balance sheet. **Chief Executive/ Director of Finance**

56. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Acting Director of Public Health [Board Paper No 06/31] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the new Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the sixty-three Medical Practitioners listed on the NHS Board paper be approved for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003. **Acting Director of Public Health**

ACTION BY

57. SITING OF NEW CHILDREN'S HOSPITAL – OUTCOME OF CONSULTATION PROCESS

A report of the Director of Acute Services, Strategy, Implementation and Planning [Board Paper No 06/32] asked the NHS Board to note the issues raised in the consultation for the new children's hospital and to approve the siting of the new hospital on the Southern General campus.

The Clinical Advisory Group appointed by the Minister and chaired by Professor Calder confirmed that the Southern General Hospital represented the most suitable and only practicable site on which to provide a new children's hospital that achieved triple co-location of adult, children and maternity services.

Ms Byrne reminded the NHS Board of the background to the consultation process and led the NHS Board through the key themes from the consultation. Forty-eight written responses were received and sixty-five delegates had attended the consultation workshop event. The themes emerging from each constituent part of the consultation were similar and Ms Byrne described how the planning team and service providers would address them. She summarised the themes to be as follows:

- Age range and adolescents
- Transport and parking
- Upgrade facilities at Southern Maternity
- Design and facilities in the new children's hospital
- Timescales
- Communications
- Non clinical services
- Emergency services
- Maternity services in West Glasgow

The consultation exercise was just the start of an extensive period of engagement on the new children's hospital and had allowed the NHS Board to gather together views from a wide range of people to inform the process over the next few years. Consultees were concerned, however, about the transport and parking and it was essential that planners worked with other agencies to improve access to the site.

Consultees agreed that raising the age range for the children's hospital to sixteen was desirable and age appropriate services would apply rather than rigid chronological roles. Young people themselves wanted to be involved in designing that environment and there was strong support for improving the transition to adult services.

Treating children with minor injuries locally was supported if it was underpinned by education and awareness raising for the general public and parents and paediatric training for those working in minor injury units.

Consultees valued the opportunity to express their views through the consultation process. They highlighted the need for good publicity and communication around the exercise and recognised that engagement must be done in a variety of ways to reach all groups. They wanted to use existing groups and structures and were clear that children and young people must be given the opportunity to air their views.

ACTION BY

In response to a question from Mrs Murray, Mr McGrogan advised that the NHS Board was in touch with a youth organisation, Local Authorities and education establishments regarding the consultation process and how it would align with children's and young people's views. He agreed that it would be important to engage with young people throughout the five-year journey, not only in the building design process but in ongoing service provision.

Councillor White remained concerned about access to services particularly from his Council area. Mr McGrogan confirmed that the NHS Board would work in partnership with transport providers to try to influence transport links to the campus.

Professor Barlow reminded the NHS Board that it was the Calder Group's vision that although delivery services would be provided at the Southern, ante-natal care would be provided more locally. This was welcomed and Ms Byrne confirmed that those involved in the planning processes would learn from good examples currently in existence in respect of ante-natal care in the city.

Mr Divers particularly welcomed the points raised in the consultation that touched on regional and national elements. He reported that work was ongoing to address these aspects.

DECIDED:

- That issues raised in the consultation for the new children's hospital which would be addressed through the detailed planning process for the project be noted.

- That the siting of the new children's hospital on the Southern General campus, the transfer of services and the related closure of the Royal Hospital for Sick Children be approved.

Director of Acute Services, Strategy, Implementation and Planning

- That Ministerial approval for the closure of the site at Yorkhill be sought.

Director of Acute Services, Strategy, Implementation and Planning

58. FINANCIAL PLAN

A report of the Director of Finance [Board Paper No 06/33] asked the NHS Board to approve the financial plan for 2006/07 for Greater Glasgow and note the indicative figures and analysis provided for the years beyond 2006/07.

Mr Griffin explained that each year the NHS Board was required to submit a five-year financial plan to the Scottish Executive Health Department. This described the NHS Board's financial plan for 2006/07 and provided indicative figures and analysis for the years beyond 2006/07. It had already been considered by the NHS Board's Performance Review Group and would be used to inform the development of a longer term financial plan for NHS Greater Glasgow and Clyde during 2006/07, involving each operational area, its director and management teams in an inclusive process, scheduled to commence in August 2006.

A draft financial plan had also been prepared for the Clyde area of the expanded Greater Glasgow and Clyde NHS Board. This was currently being finalised and would be submitted to the Performance Review Group and NHS Board in due course.

Director of Finance

Mr Griffin led the NHS Board through the plan and highlighted the following key points:

ACTION BY

- The Board was forecasting the achievement of financial breakeven over a five-year period to 2010/2011.

- The financial plan provided for an estimated net additional cost associated with accelerating the achievement of an eighteen-week waiting time target from the original target date of December 2007 to December 2006. The net additional recurring investment required to achieve this, commencing in 2006/07, after taking account of additional funding contributions anticipated from other NHS Boards and the national waiting times unit, was £4.9M.

- The financial plan provided for the latest forecast of additional funding required to support implementation of the acute services review together with other identified service commitments.

- The financial plan incorporated a Greater Glasgow cost savings plan for 2006/07 and 2007/08.

Mr Griffin summarised the revenue funding plan describing the main funding sources which the NHS Board would deploy to cover its expenditure commitments. He highlighted the extent to which the NHS Board's expenditure commitments were underpinned by non-recurring funding and provided an overview of the forward financial plan showing how new recurring revenue resources might prospectively be allocated.

In response to a question from Councillor Collins, Mr Griffin confirmed that a specific additional provision of £7M had been made for additional expenditure on energy in 2006/07 taking account of recent price movements associated with the supply of gas and electricity. In this regard, Sir John confirmed that increased energy costs had been discussed at the Chairmen's Group meetings with the Minister.

Councillor White raised the point that CHPs forecast their financial plans over a three year period and suggested that if there would be merit in aligning this to a five year period to be in sync with the NHS Board.

DECIDED:

- That the financial plan be approved. **Director of Finance**

- That the indicative figures and analysis provided for the years beyond 2006/07 be noted. **Director of Finance**

59. MODERNISING MEDICAL CAREERS – RESPONSE TO THE IMPLEMENTATION OF FOUNDATION TRAINING

A report of the Medical Director [Board Paper No 06/34] asked the NHS Board to note the update on the next stage of the implementation of Modernising Medical Careers and the identification of the posts to take on roles currently performed by Senior House Officers (SHO).

Dr Cowan referred to the work undertaken by the Monitoring Medical Careers Implementation Group which had been considering the service impact of implementation. Their work initially considered the introduction of the first year of Foundation Training which was introduced in August 2005 and replaced Pre-registration House Officer (PRHO) posts. The introduction had gone smoothly with no impact on service, however, absorbing the additional supervision requirements had taken up Consultant time. Foundation Year 2 (FY2) would commence on 1 August 2006 with all current FY1 doctors entering into a further year of Foundation Training – this year replaced the current first year of SHO training and differed considerably from current SHO training.

Dr Cowan described the effects of FY2 on service delivery where it was expected there would be a direct impact. Furthermore, an initial estimate of the total cost of FY2 purely on the basis of a straight replacement of lost SHO hours by SHOs came to £3M for NHS Greater Glasgow. A more robust estimate of the total, including Clyde, was produced based on stricter criteria and the total full year costs were £2.37M for NHS Greater Glasgow and Clyde – the Director of Finance had made provision for the part year costs in the 2006/07 financial plan.

Dr Cowan advised that the key additional posts had been identified as follows:

- Nurse specialists/optometrists/extended scope practitioners
- SHO posts in:
- A & E
- Medicine/surgery/orthopaedics
- Obstetrics

DECIDED:

That the update on the next stage of the implementation of Modernising Medical Careers and identification of posts to take on roles currently performed by Senior House Officers be noted.

60. CONSULTATION ON NATIONAL TRANSPORT STRATEGY

A report of the Head of Community Engagement and Transport [Board Paper No 06/35] asked the NHS Board to note that the Scottish Executive Health Department was consulting on the National Transport Strategy and to endorse the significant elements of an NHS Greater Glasgow and Clyde response to this strategy as outlined.

Mr McGrogan described the Scottish Executive consultation which set out key questions about Scotland's transport future which were to be addressed on the development of a National Transport Strategy.

He highlighted concerns which had previously been noted about public transport in Greater Glasgow and outlined critical points for the NHS Board's response which would be developed further through the Corporate Planning Policy and Performance Group.

He acknowledged some particular concerns with public transport in the Greater Glasgow and Clyde area and welcomed the overtures by Strathclyde Partnership for Transport to form a strategic relationship with the NHS Board in order to work collaboratively towards improving transport services for patients, visitors and staff.

ACTION BY

Overall, the NHS Board welcomed the development of Scotland's first National Transport Strategy, noted that it would set the strategic context for regional transport strategies and would shape the way public monies were spent over the next seven years on transport initiatives.

DECIDED:

- That the Scottish Executive consultation on the National Transport Strategy be noted.

- That the significant elements of an NHS Greater Glasgow and Clyde response to the strategy as outlined be endorsed. **Head of Community Engagement and Transport**

- That the importance of transport to aspects of public and individual health, access to health care and wellbeing, economic prosperity and environmental concerns be acknowledged.

61. NHS GREATER GLASGOW AND CLYDE – CHILD PROTECTION FORUM UPDATE

A report of the Board Nurse Director [Board Paper No 06/36] asked the Board to note the progress made by the NHS Greater Glasgow and Clyde Child Protection Forum since December 2005 and agree to receive a further update in December 2006.

Ms Crocket described the work of the Child Protection Forum which continued to be rooted in the key objectives of the policies that informed child protection work as well as messages from national enquiries and the Government's vision for children. She described the work of the Child Protection Unit, its staff and two Operational Focussed Groups that had been introduced (one covering the Acute Division, the second covering NHS Partnerships).

Ms Crocket described key achievements of the Child Protection Unit and work ongoing to further progress developments including:

- Advice and support to staff
- Management information
- Significant case reviews
- Research and knowledge development
- Staff consultation on children's service/child protection issues
- Child protection committees and work with other Authorities

In response to a question from Ms Murray, Ms Crocket confirmed that CHCP/CHP Directors had responsibility to ensure mechanisms were in place at partnership level to lead on child protection work. It also formed part of their Performance Management Review.

DECIDED:

- That progress made by NHS Greater Glasgow and Clyde's Child Protection Forum be noted.

- That a further progress report be submitted to the NHS Board in six months time. **Nurse Director**

ACTION BY

62. GOVERNANCE ISSUES – COMMITTEES AND CHCPs/CHPs

A report of the Head of Board Administration [Board Paper No 06/37] asked the NHS Board to approve the revised remits of various Standing Committees and approve the revised membership of each of the CHP and CHCP Committees and the move to hold these Committee meetings in public.

Mr Hamilton summarised the revisions made to the Standing Committees of the NHS Board since December 2005. He explained that in accordance with the partnership agreement for the West Dunbartonshire Council Health Improvement and Social Justice Partnership each Member required a named deputy member. Mrs Rani Dhir represented the NHS Board on this partnership and he asked any Member interested in the position of deputy to make contact with the NHS Board Chairman.

Mr Hamilton led the NHS Board through the membership update of each of the CHCP and CHP Committees. As Subcommittees of the NHS Board, they also operated under the NHS Board's Standing Orders. As such, these Committees had been considering the issue of moving to hold their meetings in public and he asked the NHS Board to approve CHCP/CHP Committees moving to hold their meetings in public.

DECIDED:

- That the revised remits of the Audit Committee, Clinical Governance Committee, Staff Governance Committee, Performance Review Group, Spiritual Care Committee and Involving People Committee be approved. **Head of Board Administration**

- That the revised membership of each of the CHP and CHCP Committees be approved. **Head of Board Administration**

- That the CHP and CHCP Committees move to hold their meetings in public. **Head of Board Administration**

63. AUTHORISED SIGNATORIES – PROPERTY TRANSACTIONS

A report of the Head of Board Administration [Board Paper No 06/38] asked the NHS Board to note the Ministerial decision to grant authority to the Chief Executive, Director of Finance, Director of Corporate Planning and Policy, Chief Operating Officer and Director of Acute Service Strategy Implementation and Planning to be authorised signatories to documents relating to the acquisition, management and disposal of land with immediate effect.

DECIDED:

That the authority granted to the Chief Executive, Director of Finance, Director of Corporate Planning and Policy, Chief Operating Officer and Director of Acute Service Strategy Implementation and Planning be authorised. **Head of Board Administration**

64. WAITING TIMES

A report of the Chief Operating Officer – Acute Division [Board Paper No 06/39] asked the NHS Board to note the progress made in meeting national waiting time targets.

Mr Calderwood advised that the waiting times report was based on NHS Greater Glasgow and Clyde information up to 31 May 2006. He highlighted the following:

ACTION BY

- The number of inpatients and day cases without availability status codes waiting over eighteen weeks reduced by 451 (31%) between April and May 2006.

- The number of inpatients and day cases waiting with availability status codes decreased by 316 (3%) between April and May 2006.

- The number of outpatients waiting over 18 weeks reduced by 728 (23%) between April and May 2006.

Mr Calderwood confirmed that the NHS Board had submitted its plans for delivery of all of the other new waiting time targets via its Local Delivery Plan to the Scottish Executive Health Department. Highlighted in that submission were the plans for some of the targets to be presented on an interim basis and currently subject to review. Separate plans have been submitted for NHS Greater Glasgow and NHS Argyll and Clyde as previously constituted as requested by the Scottish Executive Health Department. A unified NHS Greater Glasgow and Clyde Local Delivery Plan would be produced and operational from 2007/08.

NOTED

65. QUARTERLY REPORT ON COMPLAINTS : JANUARY – MARCH 2006

A report of the Head of Board Administration, Chief Operating Officer, Acute and Lead Director, CHCP (Glasgow) [Board Paper No 06/40] was submitted setting out the quarterly report on complaints handling within NHS Greater Glasgow for the period January to March 2006.

Mr Hamilton advised that this would be the last report on the old organisational structure and the format of the next report would be statistical information reporting on the Acute Service Division, Mental Health Partnership, CHCPs (six) and CHPs (four). At the same time, a new format report would also be introduced for the Clinical Governance Committee focussing on action taken as a result of complaints and organisational learning.

NOTED

66. STAFF GOVERNANCE COMMITTEE MINUTES: 17 AUGUST 2005 AND 6 MARCH 2006

The Minutes of the Staff Governance Committee meeting held on 17 August 2005 [SGC(M)05/3] and 6 March 2006 [SGC(M)06/1] were noted.

NOTED

67. AREA CLINICAL FORUM MINUTES: 27 APRIL 2006

The Minutes of the Area Clinical Forum meeting held on 27 April 2006 [ACF(M)06/3] were noted.

NOTED

ACTION BY

68. AUDIT COMMITTEE MINUTES: 8 MAY 2006

The Minutes of the Audit Committee meeting held on 8 May 2006 [A(M)06/3] were noted.

NOTED

69. CLINICAL GOVERNANCE COMMITTEE MINUTES : 5 MAY 2006

The Minutes of the Clinical Governance Committee meeting held on 5 May 2006 [HCGC(M)06/2] were noted.

NOTED

70. PHARMACY PRACTICES COMMITTEE MINUTES: 5 APRIL 2006

The Minutes of the Pharmacy Practices Committee meeting held on 5 April 2006 [Paper No. 06/41] were noted.

NOTED

71. WEST GLASGOW COMMUNITY HEALTH CARE PARTNERSHIP COMMITTEE MINUTES : 6 APRIL 2006

The Minutes of the West Glasgow Community Health Care Partnership Committee meeting held on 6 April 2006 [GCHCPC(West)(M)06/02] were noted.

NOTED

72. CHP SOUTH LANARKSHIRE – OPERATING MANAGEMENT (PERFORMANCE MANAGEMENT) COMMITTEE MINUTES : 22 MAY 2006

The Minutes of the CHP South Lanarkshire – Operating Management (Performance Management) Committee meeting held on 22 May 2006 [Board Paper No 06/42] were noted.

NOTED

73. EAST RENFREWSHIRE CHCP COMMITTEE MINUTES : 19 APRIL 2006

The Minutes of the East Renfrewshire CHCP Committee meeting held on 19 April 2006 [Board Paper No 06/43] were noted.

NOTED

74. PERFORMANCE REVIEW GROUP MINUTES : 16 MAY 2006

The Minutes of the Performance Review Group meetings held on 16 May 2006 [PRG(M)06/03] were noted.

ACTION BY

In respect of Minute No 26 (a), it was agreed that the NHS Board delegate full authority to the Performance Review Group to act on the NHS Board's behalf on approving the necessary steps to complete for contractual sign-off for the new Stobhill and Victoria Hospitals. **Chief Executive**

NOTED

75. EXCLUSION OF PUBLIC AND PRESS

On the motion of Mrs Smith and seconded by Mr Cleland the Board agreed to exclude the public and press during consideration of the item listed in Part II of the agenda in view of the confidential nature of the business to be transacted.

76. FHS DISCIPLINARY REFERRAL – REPORT FROM LANARKSHIRE DENTAL DISCIPLINE COMMITTEE

A report of the Head of Primary Care Support [Board Paper No 06/44] asked the NHS Board to give consideration to the recommendations of the Lanarkshire Dental Discipline Committee in respect of these referrals and the further information as presented at Appendices A, B, C, D and E.

Mr N Zappia explained the background to these two disciplinary referrals and their outcomes. He summarised the discipline procedures and the findings of the Discipline Committee.

DECIDED:

- That the recommendations of the Lanarkshire Dental Discipline Committee in respect of the two referrals be accepted. **Head of Primary Care Support**

- That the FHS disciplinary procedures form a topic of discussion at a future NHS Board Seminar. **Head of Primary Care Support**

The meeting ended at 1.45 pm

NHSGG&C(M)07/1
Minutes: 1 - 25

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 20 February 2007 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair) (to Minute No 24)

Mr J Bannon
Dr L de Caestecker (to Minute No 24)
Mr G Carson
Mr R Cleland
Councillor J Coleman
Councillor D Collins
Dr B Cowan
Ms R Crocket (to Minute No 24)
Ms R Dhir MBE
Mr T A Divers OBE
Councillor R Duncan
Councillor T Fyfe (to Minute No 24)
Mr D Griffin
Dr R Groden
Mr P Hamilton
Councillor J Handibode
Dr M Kapasi MBE
Mrs S Kuenssberg CBE (from Minute No 7)
Ms G Leslie
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Mr A O Robertson OBE (in the Chair for Minute No 25)
Councillor M Rooney
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE
Councillor T Williams
Mr B Williamson

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning (to Minute No 24)
Ms D Cafferty	..	Planning Manager, Women and Children's Acute Services Planning (for Minute No 6)
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division (to Minute No 24)
Mrs E Cameron	..	Member, Scottish Committee of Councils on Tribunals (for Minute No 25)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications (to Minute No 24)
Mr I Reid	..	Director of Human Resources (to Minute No 24)
Mr S Reid	..	Planning Manager, Clyde Acute Services (for Minute No 5)
Ms C Renfrew	..	Director of Corporate Planning and Policy (to Minute No 8)
Mr D Walker	..	Head of Performance Management and Corporate Reporting (to Minute No 8)
Mr N Zappia	..	Head of Primary Care Support (for Minute No 25)

B Y I N V I T A T I O N

Dr D Colville	..	Vice Chairman, Area Medical Committee (to Minute No 24)
Mr D Thomson	..	Chairman, Area Pharmaceutical Committee (to Minute No 24)

ACTION BY

1. WELCOME AND APOLOGIES

Apologies for absence were intimated on behalf of Professor D Barlow and Ms A Paul.

The Chairman welcomed two new Board Members, namely, Councillor Martin Rooney (representing West Dunbartonshire Council) and Mr Grant Carson (Non Executive Member) to their first meeting. Sir John also recorded that it would be the last NHS Board meeting for Sally Kuenssberg and Richard Groden whose terms of office expired on 31 March 2007. He thanked them both for their commitment and contribution to the work of the NHS Board throughout their period of office.

2. CHIEF EXECUTIVE'S UPDATE

(i) On 18 January 2007 Mr Divers and senior NHS Board colleagues had met with representatives from the Healthcare Associated Infection (HAI) Task Force. Collectively, they discussed the Task Force's detailed action plan and recommendations and looked at local NHS Board performance; benchmarking this against NHS Scotland. This had been a good meeting and Mr Divers hoped to engage further with the Task Force in the future to address infection control.

(ii) Mr Divers and Keith Redpath (Director, West Dunbartonshire Community Health Partnership) had met with representatives from Her Majesty's Inspectorate of Education (HMIE) to discuss the inspection of children's services and child protection arrangements within the West Dunbartonshire Council area. Leaders of the Council were looking at a strategic approach to address these issues and this had proved to be a useful exchange at that level particularly in examining cases and local arrangements.

(iii) Mr Divers, Ian Reid and NHS Board colleagues had attended an employability event at the Beardmore Hotel on 8 February 2007. This looked at how the NHS could support employability across NHS Greater Glasgow and Clyde. It had been an upbeat session with representatives in attendance from the public and voluntary sectors as well Scottish Enterprise. Collectively, all agencies hoped to continue to support employability across the area.

NOTED

3. MINUTES

On the motion of Mr A O Robertson, seconded by Councillor D Collins, the Minutes of the meeting of the NHS Board held on Tuesday, 19 December 2006 [GG&CNHSB(M)06/6] were approved as an accurate record and signed by the Chairman.

4. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list was circulated and noted.

ACTION BY

(ii) Mr Divers confirmed that verbal feedback had been received on the two HMIE inspection visits that had taken place within NHS Greater Glasgow and Clyde. One had looked at the provision of services to asylum seekers and the other concerned the child protection arrangements in West Dunbartonshire. To date, positive feedback had been received in service delivery standards. In relation to the child protection arrangements, it was expected that one of the recommendations may include the need for the NHS Board to engage with children more in terms of planning of services. In relation to the inspection on the provision of services to asylum seekers, further thought was being given by HMIE on their application of some of their standards and what they measured. Written reports were expected on both by April 2007

NOTED

5. A SUSTAINABLE FUTURE FOR HOSPITAL SERVICES IN INVERCLYDE AND RENFREWSHIRE – OUTCOME OF CONSULTATION PROCESS

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 07/1] asked the NHS Board to note the outcome of the consultation on future hospital services in Inverclyde and Renfrewshire, approve the strategy and note that, subject to approval, Ministerial approval would be sought for the changes to Inverclyde Royal Hospital (IRH) and the Royal Alexandra Hospital (RAH).

Ms Byrne thanked staff from NHS Greater Glasgow and from Clyde who had collectively contributed to the issues in this consultation. She also thanked members of the public who had attended the public meetings and those who had responded formally to the consultation exercise through which the NHS Board had received significant support for its proposals.

Ms Byrne summarised the future strategy for adult acute services at the RAH in Paisley and the IRH in Greenock which included the following:

- A & E services and major emergency receiving services in general medicine, general surgery and trauma and orthopaedics would be retained at both the IRH and RAH.

- Day case and outpatient facilities at both hospitals required investment and modification to support the delivery of modern models of health care. Detailed work on the investment required in these facilities would be undertaken over the coming months.

Ms Byrne outlined the reasons why changes needed to be made to the inpatient or emergency provision of a number of the smaller specialty areas and linked this with the number of patients that would be affected by these changes.

Ms Byrne outlined the formal consultation process which ran from 8 December 2006 to 2 February 2007 and highlighted the number of strands which had been undertaken as part of that process which included:

- Staff meetings – held at both the IRH and RAH and included wide staff groupings, Consultants, the Area Partnership Forum and the Acute Partnership Forum.

- Consultation material and communications campaign – a co-ordinated communications campaign was undertaken to ensure that the information relating to the consultation was widely available. There were two target groups for this material; internal and external.

ACTION BY

- Public events – 6 public events were held in January 2007 at which members of the public, patients and voluntary groups and community representatives heard a presentation on the strategy and aired their views.

- Patient focus groups – for dermatology, vascular surgery, ENT and urology. These focus groups proved extremely useful both from the NHS and patient perspective.

- Written responses – 93 formal written responses had been received.

The key themes emerging from each of the strands of the consultation were grouped into several key areas:

- Support for the proposals – the main feedback from both written responses and also at public meetings had been support for the proposals – particularly the retention of Accident and Emergency Services at the IRH.

- Transport and access – transport and access to hospital services was an issue raised at each of the public meetings and also in the patient focus groups. The Community Engagement and Transport Team would liaise with community groups to determine how these issues could be best addressed.

- Capacity planning for future changes – to ensure that the sites where services would be located were appropriately resourced, two strands of work were required to ensure this; firstly the resource required at the receiving site in order to meet the additional workload and, secondly, the impact on the current site that potential changes would have.

- Acceptance of the need for change – most of the people who took part in the consultation recognised that there was a need for change and understood the rationale for the centralisation of specialist services.

- Dermatology services – there was commitment to address the issues that had arisen regarding the proposed move of inpatient dermatology services and these would be worked through with staff and patient groups. The vast majority of dermatology services would remain at RAH with planned improvements in outpatient and day treatment facilities. In relation to how this would be taken forward, a Community Engagement Manager, in tandem with staff from the Acute Division, would work with patients and carers in the process of redesigning services.

- Other issues – further discussion would take place with colleagues in the Scottish Ambulance Service.

Ms Byrne confirmed that the overwhelming response to the consultation proposals on the future of hospital services in Inverclyde and Renfrewshire had been positive. There were concerns around the specialty areas already identified and these would be further discussed with patient and staff involvement. Detailed capacity planning work needed to be undertaken with clinicians and managers in both Clyde and Glasgow to identify the models of care that would be developed. Ms Byrne outlined the timescales in which the changes could be enacted.

Sir John extended his thanks to the clinical staff on both sites who had embraced the concept of joint working. Mr Williamson echoed this point and agreed that although some operational issues remained to be worked through, clinical staff had welcomed the clarity that this strategy had brought to services at both the IRH and RAH. He also commended the pace at which the strategy had, so far, moved.

ACTION BY

In response to a question from Mr Cleland, Mr Calderwood confirmed that following NHS Board approval to the strategy, Ministerial approval would be sought. Thereafter, between the end of 2007 and 2011, various operational activities would be amended to reflect the new strategy taking into account the overall timetable for the acute services redesign and rationalisation.

Mr Divers emphasised the importance in the phased programme of work to ensure that momentum was retained. It was vital to bring to an end the period of uncertainty that had been present for many years within the Clyde area. He also referred to the Health Needs Assessment work for the north of the Clyde that was being led by Dr de Caestecker, Director of Public Health. The progress of this work would be presented to West Dunbartonshire Council at its meeting during the following week together with a description of the NHS Board's intention and commitments regarding planning over the coming months.

Dr Kapasi also welcomed implementation of the strategy and hoped that the NHS Board would now be able to focus on filling substantive appointments to enable continued sustainable high quality benefits to patients.

DECIDED:

- That the outcome of the consultation on future hospital services in Inverclyde and Renfrewshire be noted.

- That the strategy for hospital services in Inverclyde and Renfrewshire be approved as follows: **Director of Acute Services Strategy, Implementation and Planning**

    - The retention of Accident and Emergency Services at both the IRH and the RAH.

    - The retention of the vast majority of inpatient services at both the IRH and the RAH.

    - The in-principle expansion of outpatient and ambulatory services at the IRH and the RAH.

    - Future changes to the inpatient (overnight stay) provision of four specialty areas: Urology (from IRH to RAH); Vascular Surgery (from IRH to Glasgow); ENT Surgery (from RAH to the Southern General Hospital (SGH)); and Dermatology (from RAH to SGH).

    - Future changes to the provision of emergency ophthalmology services (from IRH and RAH to Gartnavel General Hospital (GGH)).

    - The detail and timing of these changes was still to be worked through with clinicians in Clyde and in Glasgow and there would be commitment to keep patients informed.

- That Ministerial approval for the changes to IRH and RAH be sought. **Director of Acute Services Strategy, Implementation and Planning**

ACTION BY

6. MODERNISATION AND UPGRADING OF ACCOMMODATION AND NEW BUILD FACILITY AT THE MATERNITY UNIT, SOUTHERN GENERAL HOSPITAL

A report of the Director of Acute Services Strategy, Implementation and Planning and Chief Operating Officer (Acute Division) [Board Paper No 07/2] asked the NHS Board to receive the Outline Business Case (OBC) for the maternity capital development on the Southern General Hospital site, approve Option 3 as the preferred option and note that the OBC, subject to NHS Board approval, would be submitted to the Capital Investment Group of the Scottish Executive Health Department for formal approval at its meeting on 6 March 2007.

Ms Byrne explained that the OBC had been developed by NHS Greater Glasgow and Clyde's Maternity Strategy Implementation Steering Group following detailed planning towards implementation of the NHS Board's maternity strategy. She summarised the historical background and context of the NHS Board's maternity strategy and explained that detailed work, over the past six months, had focussed on the proposals to best deliver the recommendations of the Calder Report in terms of maternity and neonatal services, which included aligning service requirements with the new children's hospital, coupled with co-location with adult services on the Southern General Hospital (SGH) campus.

In taking forward this work, three capital options evolved and she led the NHS Board through the detail of these three options setting the context in terms of non-financial work and financial appraisal. Following this work, Option 3 had been agreed as the preferred option as it took account of all of the recommendations in the Calder Report and provided mainly new facilities with some refurbishment giving the adjacencies required. This option also met target timescales and provided a state of the art neonatal and labour suite facility with a much longer life. In summary, it provided:

- Construction of a new three storey facility – two storeys for the neonatal service including provision for integrating medical and surgical intensive care cots (currently in the Royal Hospital for Sick Children) and new labour suite and obstetric theatres.

- New single storey interventional fetal medicine unit.

- Demolition of Ward 40.

- Refurbishment of the existing labour ward as day care, triage and EPAS.

She summarised the outline programme which would see overall completion (including refurbishment) by December 2010.

In response to a question, Ms Byrne confirmed that the service model took cognisance of not only other NHS Scotland models but UK-wide. It also reflected the differences in current practice across NHS Greater Glasgow and Clyde that existed and changed the way in which maternity services would be delivered including a triage and midwife led system. Mr Calderwood re-iterated that the model had been benchmarked with other maternity hospitals and had the backing of the majority of clinical staff.

Dr Kapasi commented that the forecast of 65 to 70 deliveries per bed was measured on an average of a five-day stay. This, in reality, was often longer than the average woman stayed so he anticipated that this figure was an accurate reflection on need.

ACTION BY

Mr Sime referred to the NHS Board's policy on managing workforce change where consultation would take place with trade unions and staff organisations in all matters relating to staff issues – he welcomed this and looked forward to progressing these issues in partnership.

DECIDED:

- That the Outline Business Case for the Maternity Capital Development on the Southern General Hospital site be received.

- That Option 3 as the preferred option be approved. **Director of Acute Services Strategy, Implementation and Planning**

- That the Outline Business Case be approved and submitted to the Capital Investment Group of the Scottish Executive Health Department seeking formal approval at its meeting on 6 March 2007. **Director of Acute Services Strategy, Implementation and Planning**

7. LOCAL DELIVERY PLAN 2007/2008

A report of the Director of Corporate Planning and Policy [Board Paper No 07/11] asked the NHS Board to approve the Local Delivery Plan (LDP) for submission to the Scottish Executive (subject to any changes agreed by the NHS Board), approve the Chief Executive to finalise the LDP in negotiation with the Scottish Executive and note that progress on the LDP, together with the outcome of monitoring by the Executive's Delivery Unit, would be reported regularly to either the NHS Board or Performance Review Group.

Ms Renfrew reminded the NHS Board that LDPs were introduced by the Scottish Executive in 2006/07 and were designed as a performance or delivery agreement between the Scottish Executive Health Department and each individual NHS Board. The 2007/08 LDP was the NHS Board's second plan – which for the first time included Clyde. It was submitted to the Scottish Executive on 16 February 2007 subject to approval by the NHS Board.

Mr Walker explained that the LDP was structured around four Ministerial objectives referred to as HEAT:

- Health
- Efficiency
- Access
- Treatment

It addressed 28 targets and reported on 31 performance measures. To meet the requirements of the guidance, the NHS Board's LDP consisted of three main parts:

- A set of narratives for each performance measure
- A set of financial templates with narratives
- A set of trajectories

Mr Walker summarised the changes from last year including the introduction of four new targets, the expansion of one existing target and the exclusion of three others.

ACTION BY

The narratives explained concisely how the NHS Board intended to achieve each target and what risks may be involved. In some cases, it also referred to data deficiencies and difficulties. Trajectories were provided for most, but not all, measures and had been prepared by the NHS Board informed by local experience and knowledge. Some trajectories were provisional but all, could in any event, be altered at any time by the NHS Board in the future with the agreement of the Executive.

Following submission of the LDP, the NHS Board would be engaged with the Executive in a process to discuss, review and sign off each performance trajectory in the plan. The aim was that the NHS Board's plan would be signed off by the end of March 2007. Thereafter, the first active monitoring by the Executive's Delivery Unit of NHS Board performance against the plan (and specifically its trajectories) would commence in June 2007 supported by the HEAT information system becoming fully operational for the first time. This would be continued on a monthly basis as far as data availability allowed. The NHS Board would be required to account for deviations between its performance and the LDP. NHS Board performance in relation to its LDP would also be a principal feature at the Ministerial Annual Review later this year.

Mr Walker explained that nationally the LDP was likely to undergo further refinement. Some of this would be as a result of experience of application but others were likely to emerge from the programme which the Executive had initiated to address some of the current weaknesses. This included work on community care, productivity, community health, child health, patient experience, workforce, health improvement and chronic disease. The outcome of the some of these workstreams may percolate into LDPs for 2008/09.

The NHS Board's LDP was intended to be integrated and consistent with other planning processes such as Delivering for Health, local and regional planning, pay modernisation planning, workforce planning and organisational development. Locally, this was being accomplished by way of the NHS Board's planning guidance and corporate performance framework.

Mr Williamson referred to target E.02T, namely, Consultant Related Productivity. He noted that the Executive was now using four measures to demonstrate Consultant related productivity. Mr Williamson clarified that Consultants worked now in teams that included social care and community care. Rather than Consultant related productivity, the target would be better geared to "team" related productivity.

Director of Corporate Planning and Policy

In response to a question regarding ambulance response times, Ms Renfrew confirmed that, to date, relevant information was not available from the Scottish Ambulance Service – this would be pursued.

Mr McLaughlin raised a point concerning some of the health improvement targets which were both out with the control of NHS Boards and operationally at CH(C)P level. Ms Renfrew agreed and noted that behavioural issues did not have a direct linear relationship to the NHS and this would be restated to the Scottish Executive's Delivery Unit. She also clarified that in relation to alcohol misuse within NHS Greater Glasgow and Clyde, the NHS Board had an Alcohol Action Team which included representatives from Local Authorities and Strathclyde Police. This demonstrated partnership working across the piece to tackle alcohol misuse and Ms Renfrew agreed that the visibility of the workings of the Alcohol Action Team could be increased at NHS Board level to heighten Members awareness of ongoing activities.

Director of Corporate Planning and Policy

ACTION BY

DECIDED:

- That the Local Delivery Plan for submission to the Scottish Executive be approved. — **Director of Corporate Planning and Policy**
- That the Chief Executive finalise the Local Delivery Plan in negotiation with the Scottish Executive. — **Chief Executive**
- That progress on the Local Delivery Plan, together with the outcome of monitoring by the Executive's Delivery Unit, be reported regularly to either the NHS Board or Performance Review Group. — **Director of Corporate Planning and Policy**

8. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 07/3] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

- That the six Medical Practitioners listed on the NHS Board Paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. — **Director of Public Health**
- That retrospective approval be granted to the one doctor previously approved by Members in order to meet the contingencies of the service. — **Director of Public Health**

9. FINANCIAL MONITORING REPORT TO 30 NOVEMBER 2006 AND MID YEAR REVIEW : 2006/07

A report of the Director of Finance [Board Paper No 07/4] asked the NHS Board to note the Financial Monitoring Report for the eight-month period to 30 November 2006 incorporating a Mid Year Review of the Annual Financial Plan.

Mr Griffin noted that the outturn for the 8-month period to November 2006 showed the level of overall expenditure running within available funding. This confirmed that the NHS Board continued to manage expenditure levels in line with budget. He summarised expenditure activities as follows:

- Acute Services – expenditure on Acute Services had continued in line with budget during October/November. All Directorates were operating within £0.5M to budgeted expenditure levels. The main cost pressures continued to be in areas of supplies expenditure, in particular the areas of instruments and surgical sundries which were showing an overspend of £1.7M. This was linked to additional activity to achieve waiting times targets. Overspends and cost pressures were being offset by underspends in other areas. The most significant challenges faced by the Acute Services Division in sustaining this position through to the year end would be managing expenditure on the achievement of waiting times targets within available funding. In addition, expenditure on energy costs had been flagged up as a key area of risk in previous reports due to volatility of energy prices, particularly during the winter period.

ACTION BY

- NHS Partnerships – expenditure in NHS partnerships was closely in line within budget for the year to date. Expenditure on primary care prescribing had remained closely in line with budget for the year to date. During the second half of the year, the impact of price changes to a range of generic drugs could be expected to take effect, producing a dampening effect on the rate of expenditure growth in the remaining part of the year.

- Clyde – the financial outturn for the Clyde area of the NHS Board's activities had remained closely in line with expectations with overall expenditure within £100K of budget. This meant that the Clyde area continued to operate at an expenditure level some £28M to £30M in excess of available recurrent funds. It was anticipated that a savings plan for 2007/08 would be firmed up by the end of February 2007 with completion of a full three year cost savings plan, aimed at addressing the full targeted amount of £30M, following on during 2007/08 as the various strands of work aimed at establishing future clinical service strategies reached their conclusion.

With regard to 2006/07, discussions with the Scottish Executive Health Department colleagues would be concluded to finalise arrangements for addressing the residual funding gap of £7.4M which existed in 2006/07.

NOTED

10. WAITING TIMES

A report of the Chief Operating Officer – Acute Services [Board Paper No 07/5] asked the NHS Board to note the progress made in meeting national waiting time targets.

Mr Calderwood reported the following:

- The national target of no patient waiting longer than eighteen weeks for inpatient or day case treatment by 31 December 2006 was achieved.

- The total number of inpatients and day cases waiting with availability status codes (ASC) increased by 410 (3%) between November and December 2006 and by 838 (7%) over the last two months between October and December. The increase was patient driven with ASC code 2 "where the patient had asked to delay admission for personal reasons or had refused a reasonable offer of admission" accounting for 67%. The remaining 33% was accounted for by ASC code A "patients under medical constraints (condition other than that requiring treatment) which affected their ability to accept an admission date if offered".

- The number of outpatients waiting over 18 weeks increased marginally by 28 (1%) between November and December 2006.

In response to a question regarding tackling the list of patients with ASC codes, Mr Calderwood confirmed that a patient's ability to attend treatment was regularly assessed after an ASC code had been applied. There was active liaison with patients on an ASC list and a series of pilots on how to interact with patients in different categories and the reason for patients having ASC codes was being worked through.

ACTION BY

Mr McLaughlin suggested that over and above interaction with individual patients with an ASC, a communications activity may help address an understanding in the public domain of ASC codes. Mr McLaws agreed that this could be looked at more broadly and would discuss this at the next Strategic Communication Directors Group which looked at what public messages could be given both locally and nationally across the NHS in Scotland.

Director of Corporate Communications

NOTED

11. PHARMACY PRACTICES COMMITTEE MINUTES : 6 DECEMBER 2006, 7 DECEMBER 2006 AND 30 JANUARY 2007

The Minutes of the Pharmacy Practices Committee meetings held on 6 December 2006, 7 December 2006 and 30 January 2007 [PPC(M)2006/07, PPC(M)2006/08 PPC(M)2007/01] were noted. The NHS Board approved the appointment of Mrs Agnes Stewart as Vice Chair of the Pharmacy Practices Committee to replace Councillor White.

NOTED

12. PERFORMANCE REVIEW GROUP MINUTES : 16 JANUARY 2007

The Minutes of the Performance Review Group meeting held on 16 January 2007 [PRG(M)07/01] were noted.

NOTED

13. INVOLVING PEOPLE COMMITTEE MINUTES : 14 NOVEMBER 2006 AND 9 JANUARY 2007

The Minutes of the Involving People Committee meetings held on 14 November 2006 and 9 January 2007 [Board Paper No 07/6] were noted.

NOTED

14. GLASGOW CENTRE FOR POPULATION HEALTH MANAGEMENT BOARD MINUTES : 7 DECEMBER 2006

The Minutes of the Glasgow Centre for Population Health Management Board meeting held on 7 December 2006 [GCPHMB(M)06/10] were noted.

NOTED

15. SOUTH EAST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP MINUTES : 1 NOVEMBER 2006

The Minutes of the South East Glasgow Community Health and Care Partnership meeting held on 1 November 2006 [Board Paper No 07/7] were noted.

NOTED

ACTION BY

16. SOUTH LANARKSHIRE COMMUNITY HEALTH PARTNERSHIP OPERATING MANAGEMENT (PERFORMANCE MANAGEMENT) COMMITTEE MINUTES : 13 NOVEMBER 2006

The Minutes of the South Lanarkshire Community Health Partnership Operating Management (Performance Management) Committee meeting held on 13 November 2006 [Board Paper No 07/8] were noted.

Councillor Handibode referred to various financial figures and information for the Rutherglen/Cambuslang locality which did not seem to be available to the CHP from the NHS Board. Mr Divers agreed to pick this up and resolve. **Chief Executive**

NOTED

17. WEST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MINUTES : 31 OCTOBER 2006

The Minutes of the West Glasgow Community Health and Care Partnership meeting held on 31 October 2006 [GCHCPC(WEST)(M)06/05] were noted.

NOTED

18. RENFREWSHIRE COMMUNITY HEALTH PARTNERSHIP MINUTES : 17 NOVEMBER 2006 AND 19 JANUARY 2007

The Minutes of the Renfrewshire Community Health Partnership meeting held on 17 November 2006 and 19 January 2007 [RCHP(M)06/3 and RCHP(M)07/1] were noted.

NOTED

19. EAST DUNBARTONSHIRE COMMUNITY HEALTH PARTNERSHIP MINUTES : 27 OCTOBER 2006 AND 22 DECEMBER 2006

The Minutes of the East Dunbartonshire Community Health Partnership Committee meetings held on 27 October 2006 and 22 December 2006 [EDCHP(M)06/04 and EDCHP(M)06/05] were noted.

NOTED

20. WEST DUNBARTONSHIRE COMMUNITY HEALTH PARTNERSHIP MINUTES : 11 OCTOBER 2006 AND 29 NOVEMBER 2006

The Minutes of the West Dunbartonshire Community Health Partnership Committee meetings held on 11 October 2006 and 29 November 2006 [WDCHP(M)06/04 and WDCHP(M)06/05] were noted.

NOTED

ACTION BY

21. EAST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP MINUTES : 14 DECEMBER 2006

The Minutes of the East Glasgow Community Health and Care Partnership Committee meeting held on 14 December 2006 [GGCHCP(East)(M)06/01] were noted.

NOTED

22. EAST RENFREWSHIRE COMMUNITY HEALTH AND CARE PARTNERSHIP MINUTES :13 DECEMBER 2006

The Minutes of the East Renfrewshire Community Health and Care Partnership Committee meeting held on 13 December 2006 [ERCHCP(M)06/5] were noted.

NOTED

23. NORTH GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP MINUTES : 27 NOVEMBER 2006

The Minutes of the North Glasgow Community Health and Care Partnership Committee meeting held on 27 November 2006 [Board Paper No 07/9] were noted.

NOTED

24. EXCLUSION OF PUBLIC AND PRESS

A motion was approved to exclude the public and press during consideration of the following item of the agenda in view of the confidential nature of the business to be transacted.

25. FHS DISCIPLINARY REFERRAL – REPORT FROM LANARKSHIRE DENTAL DISCIPLINE COMMITTEE

Mr A O Robertson chaired the meeting for this item.

A report of the Lanarkshire Dental Discipline Committee [Board Paper No 07/10] asked the NHS Board to consider the recommendations of the Lanarkshire Dental Discipline Committee in respect of this referral and the further information as presented.

Mr Robertson welcomed Mr Zappia, Head of Primary Care Support and Mrs E Cameron, Member of the Scottish Committee of Councils on Tribunals.

Mr Zappia explained that the report was the outcome of a disciplinary referral made on behalf of NHS Greater Glasgow and Clyde by the Reference Committee on 15 August 2005 against a General Dental Practitioner on the NHS Board's Dental List.

ACTION BY

DECIDED:

- That the first recommendation made by Lanarkshire's Dental Discipline Committee be agreed. **Head of Primary Care Support**

- In relation to the second recommendation, as the necessary prior approval had not been obtained, the payment would be withheld in this case. **Head of Primary Care Support**

The meeting ended at 12.15 pm

NHSGG&C(M)07/5
Minutes: 97 - 127

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 23 October 2007 at 9.30 am

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P R E S E N T

Professor Sir J Arbuthnott (in the Chair)

Mr J Bannon MBE
Dr C Benton MBE
Mr G Carson
Dr L de Caestecker
Mr R Cleland
Councillor J Coleman
Dr D Colville
Dr B Cowan
Mr P Daniels OBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Dr M Kapasi MBE
Councillor D MacKay
Councillor J McIlwee
Mr G McLaughlin
Ms A Paul
Mr A O Robertson OBE
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE
Mr B Williamson
Councillor D Yates

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Ms S Gordon	..	Secretariat Manager
Ms L Kelly	..	Head of Policy
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy

B Y I N V I T A T I O N

Mrs G Leslie	..	Chair, Area Optometric Committee

ACTION BY

97. APOLOGIES

Apologies for absence were intimated on behalf of Professor D Barlow, Ms R Crocket, Ms R Dhir MBE, Councillor J Handibode, Mrs J Murray, Mrs R K Nijjar, Councillor I Robertson and Councillor A Stewart.

98. CHAIRMAN'S REPORT

(i) Sir John referred to the Board's Annual Review meeting which had taken place with the Cabinet Secretary on 10 October 2007.

ACTION BY

Mr Divers reported that the Cabinet Secretary and her senior officers had had three meetings in the morning session; firstly with the Board's Area Clinical Forum, secondly with the Area Partnership Forum and thirdly with a Patients Group, facilitated by the Scottish Health Council. Following that, the Cabinet Secretary visited the Keep Well Project at Springburn Health Centre where she met with staff and patients.

Sir John reported that the afternoon session was the formal Annual Review meeting and was attended by around 300 people. Sir John had introduced the session by presenting the Board's self-assessment on progress made to transform health and health services in ways that would bring many benefits to local citizens. Key areas were probed by the Cabinet Secretary encouraging interesting debate. The Cabinet Secretary had concluded by saying that it was her intention to engage further with the audience in future years striking a balance between engaging with those in attendance as well as probing Board senior officers. This approach was welcomed by Sir John.

(ii) Sir John had attended a meeting with the Scottish Further and Higher Education Funding Council on 22 October 2007 to discuss the consequences of the restructuring of NHSGGC's workforce. The Board employed around 44,000 staff and it was important to engage with local colleges and universities to ensure, as much as possible, that their structures and courses were consistent with the demands of the wider NHS and, in particular, Board functions. A joint funding and employability agenda would be compiled to ensure future partnership working linking further educational establishments with local communities and employers.

NOTED

99. MINUTES

On the motion of Dr C Benton, seconded by Councillor J McIlwee, the Minutes of the meeting of the NHS Board held on Tuesday, 21 August 2007 [NHSGG&C(M)07/4] were approved as an accurate record and signed by the Chairman.

100. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was circulated and noted.

NOTED

101. DESIGN ACTION PLAN

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 07/41] asked the NHS Board to approve the draft Design Action Plan and agree to its submission to the Scottish Government Health Directorate.

Ms Byrne explained that the draft Design Action Plan had been compiled in accordance with the NHS Circular, NHS HDL 58 (October 2006) : A Policy on Design Quality for NHS Scotland. It was required to reflect the NHS Board's commitment to achieving design quality and set out the measures that the NHS Board would take to deliver its aspirations. An NHSGGC Design Champion Network (with representation from across all organisational entities) had been established to co-ordinate the development of the Design Action Plan.

ACTION BY

Ms Byrne summarised the activity undertaken by this Network to produce the draft Design Action Plan which included a wide stakeholder event facilitated by Architecture and Design Scotland.

In terms of next steps, Ms Byrne confirmed that the NHS Board's Capital Planning Group would formally receive the draft Design Action Plan in November and thereafter take a lead role in its implementation. Implementation of the Action Plan would be tested in relation to Barrhead Health Centre and Parkhead Hospital developments over the next few months. The Design Champion Network would oversee the production of supplementary guidance to support the implementation of the Design Action Plan through the capital planning process. The Network would also review the implementation testing of the Plan undertaken in the Barrhead and Parkhead developments and would oversee necessary amendments to the Design Action Plan.

Mr P Hamilton asked how success of the Barrhead and Parkhead developments would be measured. Ms Byrne referred to the Action Plan objectives in Section 7 of the Plan and confirmed that measurement would take place in terms of whether the Plan's vision, principles and scope had been met. Mr Robertson commented that aesthetics and any knock-on effect in relation to quality of patient care were difficult to measure and distinguish but welcomed the guidance that would be developed. Ms Byrne confirmed that measuring patient impact was important and this would be worked through at a later date.

Mrs Stewart referred to the Plan's three appendices and asked that these be linked to the evaluation of the Barrhead and Parkhead developments so that achievements and the process steps could easily be identified for each one. **Director of Acute Services Strategy, Implementation and Planning**

DECIDED:

- That the draft Design Action Plan be approved **Director of Acute Services Strategy, Implementation and Planning**

- That the draft Design Action Plan be submitted to the Scottish Government Health Department be agreed. **Director of Acute Services Strategy, Implementation and Planning**

102. REPORT OF THE DIRECTOR OF PUBLIC HEALTH : A CALL TO DEBATE : A CALL TO ACTION – A REPORT ON THE HEALTH OF THE POPULATION OF NHS GREATER GLASGOW & CLYDE 2007-2008

A report of the Director of Public Health [Board Paper No 07/42] asked the NHS Board to receive the draft report on the health of the population of NHSGGC 2007 to 2008. Dr de Caestecker asked that the NHS Board note the key messages from the report and its proposed actions and support its implementation – the official launch of the report would take place on 31 October 2007.

Dr de Caestecker presented the key messages from the report which had been generated by data in "Let Glasgow Flourish". She summarised these as follows:

- There were key lessons to be learned from what was getting better – including smoking, coronary heart disease, employability and health protection.

- Health inequalities were increasing – inequalities had a differential and compounding effect on health including the effect of gender, sexual orientation, race and faith and learning disability.

ACTION BY

- Our least healthy communities were unlike our healthy communities in every way – there must be a focus on interventions while people were young and resources needed to be moved to early years, including early education, child care and support for vulnerable families and young people.

- Significant changes were taking place in our population – planning processes must recognise the importance of links between structures, environments and well-being in order to address the changing needs of current and future populations.

- The obesity epidemic must be taken seriously – this should include implementing the Infant Feeding Strategy and removing unhealthy snack provision in public buildings including hospitals and leisure centres.

- Alcohol was an increasing problem – alcohol was a major preventative cause of ill-health and premature death within NHSGGC and cirrhoris mortality rates were worsening at a faster rate than the rest of Scotland, UK or Western Europe.

- Sustainability should become a more explicit consideration for the NHS. Plans would be developed for recycling, green travel and energy efficiency as well as sustainable solutions incorporated into new build facilities.

Dr de Caestecker explained that the report was primarily aimed at community planning partners as a mechanism through which services could be planned and improved. Local Authority partners, in particular, had a key role to play in the design of the environment, access to opportunities for physical activity, availability of healthy food and drink and economic growth. All public organisations had an important role as exemplar employers in responding to the health of employees and their families and responding to the challenges of inequality, sustainability and climate change. In addition, many of the NHS Board's significant health challenges would require action by the Scottish Government, including those relating to income and to the price and availability of healthy and unhealthy food and drink. NHSGGC, with its partners, would continue to work with the Scottish Government to influence future policy on these issues.

Dr de Caestecker's intention was that the report be used as a subject of debate on public health issues and that community planning partnerships use the priorities for action to inform the joint planning that was being undertaken to improve the health of the population with a continued focus in addressing inequalities.

Mr Williamson agreed that legislation was required to action many of these health challenges and welcomed Dr de Caestecker's confirmation that the NHS Board would work with the Scottish Government to progress this jointly to tackle these hard issues locally.

Councillor MacKay advised that Dr de Caestecker had discussed these issues with Renfrewshire CHP where her report had been well received. He supported the recommendations within the plan and asked that as well as providing free or subsidised school meals (an action point on page 55 of the plan) this include the promotion of such school meals.

Director of Public Health

Mr Robertson wondered how the various initiatives would be prioritised and evaluated. Dr de Caestecker confirmed that projects such as the school meals and Keep Well would be evaluated prior to any decision being made on their roll-out. Furthermore, a focussed action plan would be compiled within each of the CH(C)P areas to ensure that local communities had an input into the prioritisation of the initiatives within their own locality. It was Dr de Caestecker's intention to meet with each of the CH(C)Ps to assist with this process.

ACTION BY

In response to a question from Mr Sime, Dr de Caestecker advised that the NHS Board's contractual arrangements with vending machine providers on hospital sites were being considered.

DECIDED:

- That the draft report of the Director of Public Health on the Health of the Population of NHSGGC 2007-08 be received. **Director of Public Health**
- That the key messages of the report and proposed actions and implementation be supported. **Director of Public Health**
- That the official launch of the report to take place on 31 October 2007 be noted. **Director of Public Health**

103. WINTER PLAN 2007/08

A report of the Director of Acute Services Strategy Implementation and Planning, [Board Paper No 07/43] asked the NHS Board to accept the update on the approach to Winter Planning for 2007/08 and agree that the plan be signed off by the Chief Executive.

Ms Byrne explained the background to the formation of the winter plan and referred, in particular, to the Winter Planning Group that met monthly and comprised all partner agencies involved in winter planning. Ms Byrne confirmed that a number of principles underpinned this year's plan particularly in learning lessons from previous years, the better use of historical data and being ready and proactive earlier. A self-assessment was carried out in accordance with the criteria set by the Scottish Government Health Directorate and submitted to them on 28 September 2007. Feedback was awaited.

Mr Calderwood referred to pressures identified in previous years within A & E Departments and outlined work ongoing to improve bed management, the creation of discharge lounges as well as looking at input from pharmacy, portering and the Scottish Ambulance service to help speed up the discharge process.

Dr Colville referred to the input general practices had in assisting with winter planning particularly in helping to reduce appointment times and aid patient access to primary care services. GEMS was working closely with NHS24 as well as local practices in this regard and GP practices had already given their commitment to help support NHS24 particularly throughout the Christmas and New Year period. Dr Colville reassured the NHS Board that at practice level contingency plans were in place in the event of a flu pandemic. Mr Divers commended work taking place between NHS24 and senior management teams at the NHS Board whereby engagement was well embedded.

In response to a question from Dr Kapasi, Mr Divers confirmed that alternatives would be provided to A & E attendance/admission in the form of same day/next day clinics and hot lines to Consultants or GPs to facilitate admission avoidance.

DECIDED:

- That the update on the approach to winter planning 2007/08 be accepted. **Director of Acute Services Strategy, Implementation and Planning**

ACTION BY

- That the winter plan be signed off by the Chief Executive be agreed. **Director of Acute Services Strategy, Implementation and Planning**

104. GLASGOW CITY JOINT ALCOHOL POLICY STATEMENT

A report of the Director of Corporate Planning and Policy and Chair, Alcohol Action Team [Board Paper No 07/44] asked the NHS Board to endorse the Joint Alcohol Policy Statement and the development of its approach with other Local Authority partners.

Ms Renfrew explained the background to the formation of the policy statement which committed partners to a challenging range of actions to tackle the problem of alcohol; in the way services were delivered; as an employer; working with suppliers and partners and in wider public policy.

Ms Renfrew explained that the policy highlighted the problems currently facing Glasgow City in relation to the consumption of alcohol across the population, attempted to tackle these problems with the commitment of partnership working to make a difference and provided a longer term strategy with shared clarity of purpose. There were five key priorities:

(i) Reduce alcohol related deaths and hospital admissions through the continuous improvement of alcohol services.

(ii) Reduce alcohol consumption levels in the whole population and in specific target groups who binged or drank harmfully.

(iii) Reduce alcohol related crime, violence and disorder.

(iv) Reduce harm to children affected by alcohol problems in the family.

(v) Promote responsible alcohol consumption among employees and raise awareness of alcohol related harm in the NHS Board's role as an employer, as a partner with a wide range of organisations and as procurer of services.

Councillor Coleman welcomed the policy which aimed to tackle alcohol problems across the City and reverse current trends. The policy sought to strengthen collective effort and take fresh steps to reverse the social and health related problems the population experienced as a result of alcohol. It was paramount to come up with new solutions and change Glasgow's drinking culture.

In response to a question from Mr Cleland, Councillor Coleman and Ms Renfrew explained the role and function of Licensing Boards and outlined how it may be possible for Local Authorities and the NHS to influence their decision making processes in the future. At the moment, Licensing Boards had a policy document out for consultation and the NHS Board would duly respond to this.

Many points were raised in relation to the availability of alcohol, its price and the effect it had on individuals as well as wider families. Given this, Mrs Smith suggested engaging the media as a partner too. **Director of Corporate Communications**

DECIDED:

- That the Joint Alcohol Policy Statement and the development of the approach with other Local Authority partners be endorsed. **Director of Corporate Communications/ Chair, Alcohol Action Team**

ACTION BY

105. BETTER HEALTH BETTER CARE DISCUSSION DOCUMENT

A report of the Director of Corporate Planning and Policy [Board Paper No 07/45] asked the NHS Board to note the process for developing NHSGGC's response to the consultation "Better Health Better Care Discussion Document" and discuss the key messages which would form the basis of NHSGGC's response.

Ms Kelly set out the broad commitments and principles for debate and discussion within the consultation document which had been launched by the Scottish Government in August 2007. The deadline for responses was 12 November 2007 – thereafter it was being published as a new action plan for health and wellbeing in mid December 2007. She explained that the document committed to maintaining the principles of the Kerr Report "Building a Health Service Fit for the Future", while ensuring that new challenges and changes were reflected incorporating specific SNP manifesto and policy commitments. Ms Kelly outlined the seven topics covered in the discussion document as follows:

- Patients' experience of care
- Best value
- Taking responsibility
- Tackling health inequalities
- Anticipatory care and long term conditions
- Best possible start
- Continuous improvement

Mr Divers confirmed that the NHS Board would focus its response on these topics and a series of key messages had emerged from discussions so far which would form the basis of NHSGGC's response. In summary these were:

- Priorities and resources
- Planning and performance framework
- Wider public sector
- Presumption against centralisation
- Evidence base
- Information technology
- Workforce
- Waiting times
- Primary care
- Mental health
- Determinants of health
- Substance misuse
- Long-term conditions
- Sustainability
- Our approach to children
- Inequalities and health improvement

In addition to these issues, the NHS Board would highlight prison health where there was no mention of the potentially very significant current feasibility study into the NHS taking responsibility for prison health. There was also no discussion of organisational structures such as ongoing commitment to CH(C)Ps.

Dr Colville sought the inclusion of optometry and what it could offer and contribute to the wellbeing of the nation. Ms Kelly agreed to highlight the importance of the primary care contribution across all four Family Health Service Contractors.

Director of Corporate Planning and Policy

ACTION BY

Similarly, it was agreed that emphasis be drawn to the demographics of the population within NHSGGC particularly in relation to high numbers of asylum seekers and refugees. **Director of Corporate Planning and Policy**

Sir John suggested that this document be discussed also at Local Authority level via the CH(C)Ps and that responses be submitted from their viewpoints.

In response to a question from Mr Daniels, Mr Divers anticipated that a separate consultation exercise would be conducted for the role and remit of Independent Scrutiny Panels. As yet, this had still to be released by the Scottish Government Health Department.

DECIDED:

- That the process for developing NHSGGC's response to the consultation be noted. **Director of Corporate Planning and Policy**

- That the key messages which would form the basis of NHSGGC's response be agreed. **Director of Corporate Planning and Policy**

106. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 07/46] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

- That the eight Medical Practitioners listed on the NHS Board Paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

107. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No 07/47] asked the NHS Board to note progress against the national targets as at the end of August 2007.

Mr Calderwood led the NHS Board through progress across the single system towards achieving waiting time and other access targets set by the Scottish Government Health Directorate – commonly known as HEAT Targets.

He reported that the Acute Division had met the maximum waiting time of 18 weeks for all patients on the true waiting list in December 2006. Furthermore, it had maintained this position since December 2006 and would continue to achieve the 18 week maximum wait in the next period.

Mr Calderwood reported that by December 2007, availability status codes (ASCs) required to be eradicated with the implementation of the "New Ways" Guidance within that timescale. Use of certain codes would cease at an earlier date starting from September 2007.

ACTION BY

Mr Calderwood referred to the 13% increase on outpatients waiting over 18 weeks between July and August 2007. A detailed review of each specialty had been undertaken to ensure that robust plans were in place to deliver the target of a maximum waiting time of 18 weeks for all new outpatients to be achieved by December 2007.

Mr Divers alluded to the 96% of Accident and Emergency patients currently being treated and discharged, admitted or transferred within four hours of arrival at the department. The December 2007 target for this was 98% and in response to a question, he confirmed that extra resources were being considered to meet this target; over and above this, the NHS Board had invested £35m to the improvement and sustaining of waiting times targets over the last four years. Work was ongoing to develop new manpower and working practices and to find other solutions to meeting waiting times targets.

NOTED

108. QUARTERLY REPORT ON COMPLAINTS : 1 APRIL TO 30 JUNE 2007

A report of the Head of Board Administration, Chief Operating Officer (Acute) and Lead Director CHCP (Glasgow) [Board Paper No 07/48] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 April to 30 June 2007.

Mr Calderwood highlighted the following from the report:

- 396 complaints had been received in the quarter (350 Acute and 46 Partnerships/Board). 16 reports had been laid by the Ombudsman before the Scottish Parliament concerning NHSGGC cases (14 Acute and 2 Family Health Service Practitioner).

- The Ombudsman reported that a recurring theme coming out of health complaints investigated was communication in the broadest sense – this was consistent with complaints received at NHSGGC where both in the Partnerships and Acute Services, communication (written and oral) was the category attracting most complaints.

- The Ombudsman had arranged to come through and talk with the Chief Executive, Chief Operating Officer (Acute) and Head of Board Administration on 30 October 2007 about some of the issues raised and policy issues which had arisen in NHSGGC cases.

Mrs Stewart asked that future reports show figures from the previous quarter so that a comparison could be shown. She also enquired if letters of commendation/plaudits could be captured in the quarterly complaints report.

Head of Board Administration

NOTED

109. FINANCIAL MONITORING REPORT TO 31 JULY 2007

A report of the Director of Finance [Board Paper No 07/49] asked the NHS Board to note the Financial Monitoring Report for the four month period to 31 July 2007.

Mr Griffin explained that at 31 July 2007, NHSGGC reported a break-even position against a year to date budget of £816.8m. This confirmed that the NHS Board continued to manage its expenditure levels in line with budget.

ACTION BY

The year end outturn was forecast to be a breakeven position against the overall revenue budget. In 2006/07, the NHS Board reported a revenue surplus of £27.3m which arose as a result of the impact of property disposals that were conducted during 2006/07. It was agreed with the SEHD that this "one off" benefit could be carried forward into 2007/08 and deployed on a non-recurring basis in the main to support the achievement of national waiting times targets by the required date of 31 December 2007.

Expenditure on Acute Services continued to run broadly in line with budget during the year to date with a breakeven position reported for the first 4 months. Expenditure on NHS partnerships was also very close to budget for the year to date, with an overall breakeven position reported. Given, however, that expenditure in Renfrewshire and Inverclyde CHPs exceeded budgeted levels due to additional expenditure on general medical services and an increased volume of prescribing activity, a review was being undertaken in view of the significant contribution which prescribing savings were expected to make to the achievement of the recurrent cost savings target for Clyde. Given that total expenditure for the Clyde area was running £0.6m above budget for the year to date, this could be attributed to these areas of expenditure pressure. The NHS Board continued to work on the development of a three year cost savings plan for addressing the recurring deficit within the Clyde area of its management responsibilities.

NOTED

110. PHARMACY PRACTICES COMMITTEE MEETING MINUTES : 8 AUGUST 2007, 22 AUGUST 2007, 18 SEPTEMBER 2007 AND 27 SEPTEMBER 2007

The Minutes of the Pharmacy Practices Committee meetings held on and 8 August 2007 [PPC(M)2007/11], 22 August 2007 [PPC(M)2007/12], 18 September 2007 [PPC(M)2007/13] and 27 September 2007 [PPC(M)2007/14] were noted.

NOTED

111. CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES : 21 AUGUST 2007

The Minutes of the Clinical Governance Committee meeting held on 21 August 2007 [CGC(M)07/4] were noted.

NOTED

112. AREA CLINICAL FORUM MEETING MINUTES : 9 AUGUST 2007 AND 20 SEPTEMBER 2007

The Minutes of the Area Clinical Forum meetings held on 9 August 2007 [ACF(M)07/4] and 20 September 2007 [ACF(M)07/5] were noted.

NOTED

ACTION BY

113. AUDIT COMMITTEE MEETING MINUTES : 11 SEPTEMBER 2007

The Minutes of the Audit Committee meeting held on 11 September 2007 [A(M)07/05] were noted.

NOTED

114. STAFF GOVERNANCE COMMITTEE MEETING MINUTES : 7 AUGUST 2007

The Minutes of the Staff Governance Committee meeting held on 7 August 2007 [SGC(M)07/2] were noted.

NOTED

115. PERFORMANCE REVIEW GROUP MEETING MINUTES : 18 SEPTEMBER 2007

The Minutes of the Performance Review Group meeting held on 18 September 2007 PRG(M)07/5] were noted.

NOTED

116. GLASGOW CENTRE FOR POPULATION HEALTH MANAGEMENT BOARD MEETING MINUTES : 13 SEPTEMBER 2007

The Minutes of the Glasgow Centre for Population Health Management Board meeting held on 13 September 2007 [GCPHMB(M)07/13] were noted.

NOTED

117. INVOLVING PEOPLE COMMITTEE MEETING MINUTES : 11 SEPTEMBER 2007

The Minutes of the Involving People Committee meeting held on 11 September 2007 [Board Paper No 07/50] were noted.

NOTED

118. WEST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MEETING MINUTES : 19 JUNE 2007 AND 14 AUGUST 2007

The Minutes of the West Glasgow Community Health and Care Partnership meetings held on 19 June 2007 [GCHCPC(WEST)(M)02/07] and 14 August 2007 [GCHCPC(WEST)(M)03/07] were noted.

NOTED

ACTION BY

119. EAST DUNBARTONSHIRE COMMUNITY HEALTH PARTNERSHIP COMMITTEE MEETING MINUTES : 29 JUNE 2007 AND 31 AUGUST 2007

The Minutes of the East Dunbartonshire Community Health Partnership Committee meetings held on 29 June 2007 [EDCHP(M)07/03] and 31 August 2007 [EDCHP(M)07/04] were noted.

NOTED

120. SOUTH EAST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MEETING MINUTES : 4 APRIL 2007 AND 12 SEPTEMBER 2007

The Minutes of the South East Glasgow Community Health and Care Partnership Committee meetings held on 4 April 2007 and 12 September 2007 [Board Paper No 07/51] were noted.

NOTED

121. NORTH GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MEETING MINUTES : 26 MARCH 2007 AND 28 AUGUST 2007

The Minutes of the North Glasgow Community Health and Care Partnership Committee meetings held on 26 March 2007 [GCHCPC(N)(M)07/03] and 28 August 2007 [GCHCPC(N)(M)07/04] were noted.

NOTED

122. EAST RENFREWSHIRE COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MEETING MINUTES : 22 AUGUST 2007

The Minutes of the East Renfrewshire Community Health and Care Partnership Committee meeting held on 22 August 2007 [ERCHCP(M)07/3] were noted.

NOTED

123. SOUTH WEST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MEETING MINUTES : 26 JUNE 2007

The Minutes of the South West Glasgow Community Health and Care Partnership Committee meeting held on 26 June 2007 [Board Paper No 07/52] were noted.

NOTED

124. EAST GLASGOW COMMUNITY HEALTH AND CARE PARTNERSHIP COMMITTEE MEETING MINUTES : 30 JULY 2007

The Minutes of the East Glasgow Community Health and Care Partnership Committee meeting held on 30 July 2007 [EGCHCP(M)07/04] were noted.

NOTED

ACTION BY

125. RENFREWSHIRE COMMUNITY HEALTH PARTNERSHIP MEETING MINUTES : 17 AUGUST 2007

The Minutes of the Renfrewshire Community Health Partnership Committee meeting held on 17 August 2007 [RCHP(M)07/05] were noted.

NOTED

126. INVERCLYDE COMMUNITY HEALTH PARTNERSHIP COMMITTEE MEETING MINUTES : 27 JUNE 2007

The Minutes of the Inverclyde Community Health Partnership Committee meeting held on 27 June 2007 [ICHP(M)07/01] were noted.

127. ANY OTHER BUSINESS

Retiral of the Chairman, Professor Sir John Arbuthnott

Mr Robertson reported that this would be Sir John's last formal NHS Board meeting prior to his retirement. He summarised the many achievements made by Sir John since taking over as Chairman in NHSGGC. His contribution had been vast and his achievements significant. Mr Robertson wished, on behalf of all NHS Board Members, Sir John a long and happy retirement.

NOTED

The meeting ended at 1.10 pm

New South Glasgow Hospital and New Children's Hospital Outline Business Case Progress Report

Board Paper

Paper No 08/01

22nd January 2008

Outline Business Case Update – New Southside Hospital and Children's Hospital

Helen Byrne, Director of Acute Services, Strategy, Implementation and Planning

Recommendation

Board Members are asked to receive the progress report on the Outline Business Case (OBC) for the New South Glasgow Adult Hospital and New Children's Hospital.

1.0 PURPOSE OF THE PAPER

The purpose of the paper is to provide the Board with an update on the progress of the OBC, in particular: the scoping and design of the New Hospitals; financial modelling; and outcome of the Gateway Review and Planning Application.

2.0 BACKGROUND

The New South Glasgow Hospitals development constitutes phase two of the Acute Services Review (ASR) and is a key part of the plan to address pressures to change the way in which acute hospital services are delivered. The fundamental drive of the ASR strategy is to reduce the number of inpatient acute adult sites from six to three. Two sites, Glasgow Royal and Southern General, will have A&E and trauma facilities, with the third inpatient site at Gartnavel General. These acute sites will be supported by two Ambulatory Care Hospitals based at the Stobhill and Victoria sites. The Acute Services Review proposals were agreed by the Health Minister, Malcolm Chisholm, in 2002.

In April 2004, following consultation, the Health Board agreed a recommendation to reduce the number of maternity units in Glasgow from three to two by transferring services from the Queen Mother's (Maternity) Hospital (QMH), to maternity units on the Southern General and Glasgow Royal Infirmary sites.

To address concerns that the Children's services would be left isolated once maternity services moved from QMH, the then Health Minister committed to the development of a new Children's Hospital for Glasgow. A Clinical Advisory Group was established which was led by Professor Andrew Calder and reported in March 2006. It recommended that the new Children's Hospital be built on the Southern site to enable ''triple location of services'' co-locating the children's hospital with both maternity and adult services.

A project team has been working over the past 18 months to develop the Outline Business Case for the New Adult and Children's Hospitals. The following sections outline the progress to date.

3.0 PROGRESS TO DATE – INTERNAL FACTORS

This section describes: the key criteria considered in positioning the new hospitals on the Southern site; the factors considered in deciding whether to build the hospital as separate buildings or an integrated facility; the development of the public sector comparator; bed modelling undertaken to inform the scope of the hospitals; the associated works in support of the new hospitals; options for delivery and work undertaken on financial modelling to identify the optimum procurement model.

3.1 Key criteria in positioning the New Hospitals on the Southern Site

One of the key criteria in considering the site of the new hospitals on the southern site is the need to physically link the new adult and new children's hospitals with both the maternity and neurosciences buildings to allow ready access to a full range of paediatric services for both foetus in utero and new born babies, and to enable pregnant mothers access to critical care and other acute services. The link between Neurosciences Building and the New South Hospital will also allow rapid access for staff between both buildings, in particular the two critical care units

It is therefore proposed to build the two hospitals in the area between the maternity and the neurosciences buildings. There a number of buildings which currently occupy this site and there is a comprehensive plan to relocate all the services within the buildings to other locations to allow demolition and clearance of the site by 2010.

3.2 Build options – Separate Buildings or an integrated building?

An option appraisal was undertaken, which looked at the benefits, risk, costs and deliverability of building the hospitals separately or as an integrated building. The preferred option identified was an integrated build to capitalise upon: the clinical synergies; the lower risk of fewer contractors on site; decreased complexity of interface issues between the two buildings with better patient flows and streamlining of processes; better deliverability and lower build and running costs due to operational synergies

3.3 Design of the preferred option for the new adult and children's hospital – development of the PSC

3.3.1 Design Option

In developing the Public Sector Comparator (PSC), several key criteria were considered, these included achieving critical co-locations within the new buildings, need for separate distinct identities a and separate entrances for both hospitals, desirability of minimal travel times throughout the building, linkage into the neurosciences, maternity and new Laboratory building, need to maintain existing hospital services during construction, availability of future expansion space and impact of the build upon neighbours.

Through consultation with technical Advisors and NHS stakeholders, a range of 5 options were initially reviewed, those which did not meet the full design requirements were deselected. Designs which did meet the full brief were then subject to further review and refinement until 3 preferred options emerged

An option appraisal was undertaken involving the design team, technical advisers, and NHS stakeholders. A tall (14 storeys) thin building as identified as the preferred configuration as it was most able to meet the above criteria.

3.3.2 Development of the Public Sector Comparator

Schedules of Accommodation were developed with the Clinical Sub-groups for both hospitals and the Board's technical advisors. Block Plans (1:500 layouts) have been designed for all hospital areas. Both the schedules and block plans have been 'clinically signed off' for the purposes of the Outline Business Case however, clinical re-design might lead to these being further developed during the next stage – albeit within the current cost envelope.

Ten key departments (5 in the new Children's Hospital and 5 in the new Adult Hospital) have been developed further to 1:200 designs. These departments have been broadly agreed as meeting the clinical needs of the departments, and further refinement will continue in the next stage of the project. The current PSC cost is based on the above work

3.4 Bed modelling to inform the size of the New Hospitals

NHS Greater Glasgow and Clyde (GGC) appointed CHKS (an independent clinical activity analysis service which the Board has worked with for a number of years) to undertake bed modelling exercises for both adult acute services across Glasgow and acute children's services.

In the 6 acute adult hospitals there are currently 3047 inpatient beds

The existing Royal Hospital for Sick Children (RHSC) has 271 beds. There are an additional 8 plus 10 beds (paediatric neurosurgery and acute adult beds) accessed by young people aged 0-15 across Glasgow that will require to be incorporated into the New Children's Hospital, giving a current total of 289 beds.

NHSGGC with input from CHKS, by incrementally applying the impact of improved performance rates, improved occupancy rates, and cognisance of predicted demographic changes, projected the bed models for adult and children's acute services.

3.4.1 Adult

In addition to the work undertaken by CHKS, modelling work has been undertaken on the future plans for 3 inpatient sites (at Glasgow Royal Infirmary, Gartnavel General Hospital and at the Southern General Hospital). Consideration has also been given to potential developments to specialist services in Glasgow and changes to patient flows from Clyde. This work has informed the potential bed configuration that supports the1109 new inpatient beds in the New South Glasgow Adult Hospital.

As this is an iterative process the bed modelling work will continue and will be updated with a 2006/7 benchmarked position, which is currently being explored to consider the further levels of efficiency that could be implemented. This will be ongoing in the months and years ahead to ensure a continued focus on efficiency.

3.4.2 Children

CHKS recommended a bed model of 245 beds. However, consideration of additional efficiencies suggested a bed model of 240 beds. This will be reviewed throughout the planning stages of the project.

3.4.3 Conclusion

In conclusion, plans for the adult hospital include 1109 beds and an Emergency Department with the capacity for 110,000 attendances per annum. The hospital will function as an acute 'hot' site with an outpatient department serving the local population and a small medical day area. The surgical day case activity will take place at the New Victoria Ambulatory Care Hospital opening in 2009.

The 240 bedded children's hospital has Emergency Department capacity for 46,000 attendances per annum. The outpatients department will see an estimated 86,000 patients per annum and the day case facility an approximate 11,000 patients per annum.

3.5 Other associated works

There are a series of other capital works associated with the new hospitals, these will be delivered through the Health Board's ongoing capital plan but their construction will be co-ordinated with the building of the new hospitals.

3.6 Options For Delivering The New South Glasgow And Children's Hospitals And Associated Works On The Southern Site

Two options to meet the scope of the project have been under consideration, the options have been identified by the Board as Option 1 and Option 1(A). In reality option 1(A) is a re-scoping of option 1 because the cost of option 1 escalated beyond affordability. Both options provide the same scope for the new acute adult and children's hospitals. Option 1 represents a whole site new build solution whilst option 1(A) refurbishes some of the existing buildings in place of the new build provision.

3.7 Financial Modelling

The Board is working with its financial advisers, in close liaison with the Scottish Government, to determine the most appropriate procurement model to deliver the New Adult Acute Hospital and New Children's Hospital.

The three models being considered are Conventional Procurement (traditional design and build), Public Private Partnership (PPP) and Non-Profit Distribution (NPD). The work is anticipated to be complete by end January 2008 and will determine value for money of adopting the preferred procured method.

The business case will also seek to demonstrate the affordability of the preferred procurement method in terms of both capital and revenue resources.

4.0 PROGRESS TO DATE – EXTERNAL FACTORS

This section gives an outline of the progress to date on the Gateway review, the Planning Application, the Social Economic Benefits analysis undertaken to assess the impact of the new hospitals on the surrounding area and beyond and the ongoing relationship and work to be completed with the Scottish Government Health Directorate (SGHD).

4.1 Gateway Review

The New South Glasgow Hospitals project is subject to Office of Government and Commerce (OGC) Gateway Review. Projects which are considered mission critical or deemed to be high risk projects are required to go through the six stages the OGC Gateway Review Process.

The review is an independent assessment of the readiness to meet the next milestone in the process of developing business cases for acquisition and procurement projects. In doing this the review outcome highlights whether aspects of the project are red, amber or green (traffic light system). Red means that the project cannot proceed to the next milestone until the issues identified as red are addressed. Amber means that the recommendations identified must be completed before the next Gateway Review stage. Green means that the programme or project is in good shape but may benefit from uptake of any green recommendations to enhance the project.

The Southern General development has completed the Gateway Review Stage 1 which was carried out on 8th, 9th and 10th of January 2008. The review was carried out by a review team consisting of 2 Office of Government and Commerce Consultants led by William Harrod and two senior technical NHS Scotland managers. !8 colleagues across GGC were interviewed as part of the Review including clinical and staff side colleagues.

The outcome of the project was that no red recommendations were issued hence the OBC can be submitted to the Board and the Scottish Capital Investment Group. The five amber recommendations and one green recommendation will be addressed before the Gateway 2 review which is likely to take place in the summer.

4.2 Planning Application

The Outline Planning Application was submitted to Glasgow City Council on 13th April 2007. The application was considered at the Glasgow Planning Committee meeting held on 15th January 2008 and received conditional approval subject to Section 75 Legal Agreement.

4.3 Social Economic Benefits Appraisal

A social economic benefits analysis was carried out by SQW Consultants, funded by NHS Greater Glasgow NHS in partnership with a number of other contributors including Scottish Enterprise and Glasgow City Council.

The analysis looked at the potential impact on the immediate area around the Southern General site, the wider city of Glasgow and the Glasgow Metropolitan City Region. The analysis identified potential benefits within the following categories: economic, human and social, knowledge (e.g. research and development) and place.

In brief SQW have estimated that the future service configurations on the Southern General site will have a combined direct, indirect and induced economic impact of between £30 and £40 million on the South West Glasgow economy; between £110 and £140 million on city economy and between £240 and £290 million on Glasgow city region by 2012/13.

The capital projects commissioned to build the new hospitals site will support between 1,300 and 1,700 construction jobs per year for the six years between 2008/09 and 2013/14. Capital projects will support between 260 and 340 jobs per year in South West Glasgow and between 650 and 850 jobs per year in the rest of the City.

Opportunities for training and employment are significant and the new hospitals development has the potential to support collaboration between academic, public and private sector partners to realise opportunities in research and development, bio-medical and life sciences

In conclusion the Southern General development is seen as a catalyst for wider social and regeneration activity contributing to the creation of higher aspirations for the physical development of the local area

4.4 Ongoing relationship with the SGHD and work to be completed

Throughout the development of the OBC there has been an ongoing discussion with and support from colleagues at the SGHD at all times. It is anticipated that the final stage of the OBC, in particular the financial sections which will seek to confirm value for money and affordability, will be concluded by late January 2008.

5.0 TIMETABLE

The estimated timetable to achieve the appropriate approvals to enable the project to move to the delivery (procurement) phase is set out below.

OBC update to Board	5th February 2008
Draft Final OBC to SGHD Capital Investment Group (CIG)	Early February 2008
Final OBC to Board	19 February 2008
CIG approval	Week commencing 26th February 2008
Submit to Cabinet	Early March 2008
Final OBC Approval	End of March 2008

6.0 RECOMMENDATION

Board Members are asked to receive the progress report on the Outline Business Case (OBC) for the New South Glasgow Adult Hospital and New Children's Hospital.

NHSGG&C(M)08/1
Minutes: 1 - 17

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 22 January 2008 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE
Mr G Carson
Mr R Cleland (to Minute 13)
Councillor J Coleman
Dr D Colville
Dr B Cowan
Mr P Daniels OBE
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Councillor J Handibode
Dr M Kapasi MBE (from Minute 6)
Councillor D MacKay (to Minute 13)
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Ms A Paul
Mr D Sime
Mrs E Smith
Councillor A Stewart
Mr B Williamson

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Ms A Hawkins	..	Director, Mental Health Partnership
Mr A Lawrie	..	Director, South Lanarkshire CHP
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Professor D Barlow, Dr L de Caestecker, Ms R Crocket, Councillor J McIlwee, Councillor I Robertson, Mrs A Stewart MBE and Councillor D Yates.

2. CHAIR'S REPORT

(i) Mr Robertson acknowledged the success of the NHS Board's Communications Department in achieving excellent media coverage in a number of the NHS Board's ongoing health initiatives. He summarised the eight key areas covered recently ranging from the NHS Winter Guide and the Smoke Free Initiative to the NHS Board's Screening Programmes and advice on the Norovirus.

ACTION BY

(ii) Mr Robertson referred to the Scottish Government's consultation document on the Local Health Care Bill – comments on which were sought by 1 April 2008. He encouraged all NHS Board Members to consider this document and provide Mr J Hamilton with their comments by the end of February 2008 so that they could be incorporated into the NHS Board's final response to the Scottish Government.

(iii) Mr Robertson alluded to recent confidential correspondence between himself and Mr Divers and the Cabinet Secretary and Chief Executive of NHS Scotland. To ensure NHS Board Members were fully briefed and kept up to date, information from Board officers had been shared with them via email. Unfortunately, it seemed that a confidential communication had been shared more widely and, as such, an investigation had been instigated into how this may have been leaked to the media. In light of this, senior officers were considering how best, in the future, to communicate confidential information with NHS Board Members.

(iv) Mr Robertson confirmed the re-appointment of six NHS Board Members from 1 April 2008 as recently confirmed by the Cabinet Secretary. The NHS Board Members were as follows:

Elinor Smith
Jessica Murray
Amanda Paul
Gerry McLaughlin
Rani Dhir
John Bannon

(v) Mr Robertson commended ongoing community engagement work taking place in relation to the new Children's Hospital and the Art in Hospitals Project for the two new hospitals at the Victoria and Stobhill sites. He had recently participated in one of these events and had been impressed with the high level of engagement with local communities and service users.

NOTED

3. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers had been accompanied by Mr Calderwood and Dr Cowan to a seminar to launch the Scottish Patient Safety Programme. This had proved an interesting event with much debate surrounding the acute hospital sector as well as identifying issues covering all parts of the NHS system. He confirmed that a report would firstly be considered by the NHS Board's Clinical Governance Committee and, thereafter, the NHS Board regarding how best to progress this programme of work throughout NHSGGC.

NOTED

4. MINUTES

On the motion of Mr R Cleland, seconded by Mrs E Smith, the Minutes of the meeting of the NHS Board held on Tuesday, 18 December 2007 [NHSGG&C(M)07/6] were approved as an accurate record and signed by the Chairman subject to the following amendments:

ACTION BY

- Page 3, item 133, fifth paragraph, Mr Carson asked that his comment reflect his request to break down the number of "respondees" – rather than "non-respondees".

- Page 7, item 136, after fourth paragraph, insert:

  "Councillor Robertson stated that the NHS Board papers were critical of the Scrutiny Panel Report for not providing remedies to the difficulties faced in convincing the local community of the reasons for the transfer of services. He felt a more generous response to the Scrutiny Panel's Report would have sent a signal of an NHS Board willing to listen and respect the views of the communities they served.

  On the financial aspect of the NHS Board's plans, Councillor Robertson stated that it was presented that the proposed changes in Clyde were not financially driven and yet a constant theme was that the recurrent deficit in Clyde had to be managed and restored without detriment to the services to those resident within the Greater Glasgow area. He believed the question of this funding deficit should be raised with the Cabinet Secretary for Health and Well-Being and that the plans to redress the recurring deficit should not only impact on services within "Clyde".

  Councillor Robertson advised that the transfer of services from the Vale of Leven to the Royal Alexandra Hospital was not an acceptable solution to residents of West Dunbartonshire – this was acknowledged by the Scrutiny Panel and if the Greater Glasgow Acute Services Review could not be altered to accept these patients north of the river then there was an urgency to ensure the viability of the services at the Vale of Leven Hospital. The integrated model of care deserved a reasonable chance to prove its worth and it was disappointing that the NHS Board and its clinicians could not produce a workable model to support local clinicians.

  Lastly, Councillor Robertson indicated that other than in general statements, the NHS Board had not offered any view of the future of the services at the Vale of Leven Hospital. The Scrutiny Panel had highlighted the absence of any vision for the hospital and this was part of the NHS Board's difficulty in not communicating effectively with local communities. It would be essential to ensure that this was a part of the consultation in order to allow people to understand what the impact of the changes would be and to understand the future of the hospital".

- Page 9, item 139, eighth paragraph, delete the words "stand along" and insert "stand alone".

NOTED

5. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was circulated and noted.

NOTED

6. OUTLINE BUSINESS CASE UPDATE – NEW SOUTH-SIDE HOSPITAL AND CHILDREN'S HOSPITAL

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/01] asked the NHS Board to receive a progress report on the Outline Business Case (OBC) for the new South Glasgow Adult Hospital and New Children's Hospital.

ACTION BY

Ms Byrne confirmed that a Project Team had been working over the past 18 months to develop the OBC for the new Adult and Children's Hospitals. She summarised their progress to date identifying both internal and external factors:

- Internal Factors – Ms Byrne explained the key criteria considered in positioning the new hospitals on the Southern General campus. Benefits, risks, costs and deliverability of building the hospitals separately and as an integrated building had been subject to an option appraisal process. Although the preferred option identified was an integrated build, Ms Byrne confirmed that the hospitals would have distinct identities and separate entrances. In terms of design, through consultation with technical advisers and NHS stakeholders, a range of five options were initially reviewed; those which did not meet the full design requirements were deselected. Designs which did meet the full brief were then subject to further review and refinement until three preferred options emerged.

  An option appraisal was undertaken involving the design team, technical advisers and NHS stakeholders. A fourteen storey building was identified as the preferred configuration as it was most able to meet the criteria. Departments had been broadly agreed as meeting clinical needs and further refinement would continue in the next stage of the project.

  In terms of bed modelling, Ms Byrne explained that plans for the adult hospital included 1,109 beds and an emergency department with the capacity for 110,000 attendances per annum. The hospital would function as an acute hot site with an outpatient department serving the local population and would have a small medical day area. The surgical day case activity would take place at the new Victoria Ambulatory Care Hospital opening in 2009.

  The 240 bedded Children's Hospital had emergency department capacity for 46,000 attendances per annum. The outpatient department would see an estimated 86,000 patients per annum and the day case facility approximately 11,000 patients per annum.

  It was the intention of the Acute Planning and Acute Divisional Teams to visit English hospital sites to compare and contrast their bed modelling with the NHS Board's plans.

- External Factors – the new South Glasgow Hospitals Project was subject to Office of Government and Commerce Gateway Review. Projects which were considered 'mission critical' or deemed to be high risk projects were required to go through the six stages of the Gateway Review process from Gateway 0 to Gateway 5. This review represented Gateway 1. Ms Byrne summarised the outcomes from this independent assessment which had been carried out on 8 - 10 January 2008. As no "red" recommendations were issued which would require immediate action, the OBC could be submitted to the NHS Board and to the Scottish Government's Capital Investment Group. The five "amber" recommendations and one "green" recommendation would be addressed before the Gateway 2 Review which was likely to take place in the summer of 2008.

  The Outline Planning Application submitted to Glasgow City Council was considered by their Planning Committee on 15 January 2008 and received conditional approval. Further discussion would be required on the Section 75 agreement.

  A socio-economic benefits analysis was carried out looking at the potential impact on the immediate area around the Southern General site, the wider City of Glasgow and the Glasgow metropolitan city region. Analysis identified potential benefits within the following categories:

ACTION BY

- Economic
- Human and social
- Knowledge
- Place

It had been estimated that the future service configuration on the Southern General site would have a combined direct, indirect and induced economic impact of between £30m and £40m on the South-West Glasgow economy; between £110m and £140m on the City economy and between £240m and £290m on Glasgow City region by 2012/13.

In conclusion, Ms Byrne confirmed that the Southern General development was seen as a catalyst for the wider social and regeneration activity contributing to the creation of high aspirations for the physical development of the local area.

Mr P Hamilton noted that the bed modelling proposals for the Children's Hospital reduced existing beds and in response Ms Byrne confirmed that the hospital had been designed flexibly to allow for increased capacity if required in the future.

Mr Carson welcomed the socio-economic benefits associated with the project and asked if it was the NHS Board's intention to work with local people. Ms Byrne clarified that the NHS Board endeavoured to work with local people and communities as the project developed and necessary skills identified. A number of principles had been developed in Glasgow in relation to such workforce issues and the NHS Board would engage with industry and local regeneration partners to take this forward.

Mr Divers explained that it was the intention of the University of Glasgow to look at how it distributed its research and academic departments across the city in light of the new Southern General campus.

DECIDED:

- That the progress report on the Outline Business Case (OBC) for the new South Glasgow Adult Hospital and new Children's Hospital be received.

7. UPDATE ON PROGRESS TO CONSULT ON MODERNISING CLYDE MENTAL HEALTH SERVICES

A report of the Director of Corporate Planning and Policy and the Director of Mental Health Partnership [Board Paper No 08/02] asked the NHS Board to note work underway to address a number of outstanding issues raised at the December 2007 NHS Board meeting prior to consulting on modernising Clyde Mental Health Services.

Ms Hawkins led the NHS Board through the Independent Scrutiny Panel's suggestion that the qualitative option appraisal process be re-run with a quantitive dimension to determine the best option for public consultation in respect of inpatient services for West Dunbartonshire. For consistency and transparency, it was decided to extend this option appraisal process to cover Clyde inpatient services. The outcome and status of the various option appraisal events undertaken to date was summarised as follows:

- West Dunbartonshire Adult and Elderly Psychiatry Acute Assessment Beds – the option appraisal process was considering nine options, including options to improve ward environments and medical cover arrangements. It would clarify the preferred option(s) and whether there was a feasible basis for meeting the preconditions of retaining services at the Vale of Leven Hospital. It was intended that a process would be complete by the end of January 2008.

- South Clyde Adult and Elderly Psychiatry Acute Admission, IPCU and Intensive Rehab Beds – two option appraisal events had been held. With regard to IPCU beds, the favoured option of locating South Clyde IPCU beds at Inverclyde Royal Hospital (within upgraded accommodation in the current short-stay psychiatric unit) scored best in the numeric appraisal and, therefore, that option would be subject to consultation.

  The option appraisal process also considered the merits of consolidating all of East Renfrewshire's elderly psychiatry acute admission beds on the one hospital campus. This relatively small number of beds was currently split across Leverndale and the Royal Alexandra Hospitals, with both hospital sites considered able to accommodate the required capacity. No definitive outcome, however, emerged from the appraisal and further work and engagement would take place, led by East Renfrewshire CHCP, to determine a recommended option.

- Clyde Addiction Beds – two option appraisal events had been held, the appraisal process concluded that Leverndale Hospital was the recommended option for locating this service.

It was anticipated that outstanding work would be completed by the end of January 2008 which would enable a formal public consultation to commence for three months from mid February 2008. In addition to the elements which required formal consultation, extensive community, service user, relative, carer and staff engagement would take place on the entirety of the Clyde Mental Health Strategy proposals.

NOTED

8. UPDATE OF PROGRESS TO CONSULT ON CLYDE MATERNITY SERVICES REVIEW

A report of the Director of Corporate Planning and Policy and Director, Clyde Acute Services [Board Paper No 08/03] asked the NHS Board to note the proposed approach to, and timing of, public consultation on the closure of the delivery services within the Inverclyde and Vale of Leven Community Maternity Units.

Ms Renfrew reminded the NHS Board that it had agreed at its December 2007 meeting to move to formal public consultation on the closure of the delivery services within the Inverclyde and Vale of Leven Community Maternity Units. She briefly updated the NHS Board on the approach to consultation, building on the extensive pre-engagement process. The NHS Board would consult on the proposal to have a single Community Maternity Unit (CMU) birthing suite for Clyde located at the Royal Alexandra Hospital. The CMUs at Inverclyde Royal Hospital and Vale of Leven Hospital would retain all other antenatal and post natal services.

Ms Renfrew confirmed that included in the consultation papers would be the full option appraisal documentation detailing the four options for service delivery, the process and evaluation of relative benefits and risks cumulating in the preferred option of a single CMU birthing suite. The Independent Scrutiny Panel report, with its full conclusions, would be included in the consultation papers to ensure openness and transparency for public comment.

ACTION BY

In line with the Independent Scrutiny Panel's conclusions that further testing of choices made by women would be of value, an audit of all women booking at the CMUs during the consultation period would be carried out to elicit reasons for their choice of delivery unit. The outcome of this audit would be included for the NHS Board along with the outcome of the consultation.

In line with statutory requirements on public consultation, Ms Renfrew outlined provision of the following arrangements:

- Public information, including summary leaflets, would be produced providing clear detailed information on the consultation process, timescales and service options.

- Public events would be held in each locality providing opportunity for public comment and questions.

- Staff would be kept fully informed and involved.

It was proposed that the public consultation process begin on Monday 3 March 2008 for three months.

NOTED

9. UPDATE ON PROGRESS TO CONSULT ON OLDER PEOPLE'S CARE AT JOHNSTONE HOSPITAL

A report of the Director of Corporate Planning and Policy and the Director, Renfrewshire CHP [Board Paper No 08/04] asked the NHS Board to note progress towards formal public consultation on the proposed changes to NHS Frail Elderly Continuing Care Services in Renfrewshire.

At the NHS Board meeting on 18 December 2007, it was agreed that a series of next steps be taken to enable NHSGGC to move to formal public consultation on the proposed closure of Johnstone Hospital and the reprovision of the NHS Frail Elderly Continuing Care Service. The steps reflected the agreed objectives of the NHS Board in responding to the Independent Scrutiny Panel report, as it related to the proposed changes to the balance of older people's care.

Ms Renfrew confirmed that work was now in hand to develop a consultation paper and this would be derived from the original NHS Board paper considered at the NHS Board meeting on 26 June 2007 (Paper No 07/26, Annex 4).

Ms Renfrew described the consultation process and referred, in particular, to a meeting that was planned for relatives and carers in late January and a meeting for staff on 1 February 2008. Consultation would commence on 4 February 2008 for a twelve week period ending 28 April 2008.

NOTED

10. CHANGES TO CLYDE INPATIENT DISABILITY SERVICES

A report of the Director of Corporate Planning and Policy and the Director of Rehabilitation and Assessment Services [Board Paper No 08/05] asked the NHS Board to note the proposed changes to specialist physical disability inpatient services and move to formal public consultation on the future service relocation.

ACTION BY

Ms Renfrew explained that in recognition of the single NHS Board-wide arrangements, the Rehabilitation and Assessment Directorate had taken the opportunity to consider issues for all areas of the NHS Board's specialist adult physical disability inpatient services. This process had involved engagement with staff, users and carers, health and social care colleagues and voluntary organisations. The NHS Board's proposals had been shaped by a number of key principles drawn from policy context and shaped further by feedback from local stakeholder engagement events and included:

- Providing services as close to home as possible.
- Supporting people at home via improved community based services.
- Strong joint working between health, social care and the voluntary sector.
- Making best use of a valuable specialist inpatient resource.
- Supporting discharge from hospital through improved discharge planning.
- Ensuring specialist services were focussed on those with most complex needs.

The specialist adult physical disability inpatient service was a small service made up of three distinct areas, namely, inpatient specialist physical disability assessment and rehabilitation, NHS continuing care and NHS respite. Ms Renfrew explained that over the past year, the NHS Board had had detailed discussion with a wide range of stakeholders, the result of which had highlighted a number of challenges that required to be addressed.

In order that the NHS Board proposals for future bed numbers were robust, a detailed analysis of the use of beds since April 2005 had been undertaken. This analysis included admission and discharge rates, occupancy levels, lengths of stay, pathways through inpatient beds and discharge destination. Ms Renfrew summarised the conclusions from this analysis highlighting that the data showed that, with some redesign of current practice and consistently achieving 80% bed occupancy levels, the specialist inpatient service now required fewer NHS inpatient beds. This analysis of bed numbers would be made available as part of the consultation material. The Consultant responsible for the service had concerns about the proposed bed numbers which also needed to be worked through during the consultation process.

Taking this into account, the NHS Board proposed a model of future service provision that recognised the shift to community based care over recent years, with intensive assessment and rehabilitation provided through a specialist inpatient physical disability rehabilitation service, supported with physical disability rehabilitation services in the community. Community services would be further developed with health and social care colleagues to provide integrated multi-agency services to adults with a physical impairment.

A reduction in bed numbers would be achieved most efficiently by the closure of beds at Islay Cottage with the transfer of four assessment/rehabilitation beds and two NHS continuing care beds to another location and rebalancing NHS continuing care/respite. In view of the isolation of the current service at Merchiston Hospital, the status quo was not considered a viable option.

As part of a pre-consultation process, comments were sought on three possible locations for the transfer of the rehabilitation beds – the Southern General, the Vale of Leven and the Royal Alexandra Hospital. The process also proposed the provision of all NHS continuing care for the NHS Board at the Southern General Hospital.

ACTION BY

Ms Renfrew summarised the assessment of each of these locations in terms of its viability and ability to meet the key principles of shifting the balance of care and supporting people at home with improved community based services. Given that the proposal was to transfer just two NHS continuing care beds, the only viable option was to increase capacity within the current NHS continuing care facility within Ward 53 at the Southern General Hospital. Future capacity requirements could be met by reassessing the balance of NHS continuing care beds with NHS respite beds and opening an additional two NHS continuing care beds within the current ward. Discussion with the Consultant in charge of Ward 53 had indicated this option was achievable with a continuation of the current flexible approach to the use of beds. It was, therefore, proposed to consult on the transfer of services from Merchiston Hospital to the Southern General with the following bed configuration:

- Physical disability rehabilitation unit, Southern General Hospital – thirty assessment and rehabilitation beds.

- Larkfield Unit PDRU, Inverclyde Royal Hospital – eight assessment and rehabilitation beds.

- Ward 53, Southern General Hospital – twenty-three NHS continuing care beds and three respite beds.

Ms Renfrew touched on the finance and workforce issues, conscious that staff were a specialist and scarce resource and, as such, clinical staff had been given the undertaking that they could all continue working within disability services if that was their wish.

A process of formal public consultation would be taken forward building on the engagement that had been ongoing since November 2006 – this would include a range of materials, meetings and briefings, a single staged event in the Renfrewshire area as well as a specific consultation response page on the NHS Board's website.

In response to a question, Ms Renfrew confirmed that as the consultation proposed a site closure, Ministerial approval required to be sought following the consultation period and decision by the NHS Board.

Councillor MacKay sought clarity around the information provided on bed numbers and highlighted the importance in the setting up of the community infrastructure.

Mr Williamson wondered what the current waiting list was for rehabilitation and assessment of patients and whether the NHS Board's proposals would induce an increase in this. Mr Calderwood reported that currently, there were five patients on the waiting list. Of these, some had declined assessment over the Christmas/New Year period with others awaiting further tests. Mr Williamson encouraged the NHS Board to monitor the bed number and waiting times issues.

Director of Corporate Planning and Policy

Ms Renfrew took on board Dr Kapasi's concerns regarding providing a service close to patients' homes. Nonetheless, this was a challenge for a small number of patients as such a small specialist service could not always be localised.

ACTION BY

Mr McLaughlin referred to the suite of Clyde consultation proposals considered by the NHS Board. He emphasised the importance of looking at these not only independently but in ensuring equity of access to them across the whole of NHSGGC. He thought it would be helpful to set out a vision on what the overall picture of service provision would look like following the outcomes of these various consultations. Ms Renfrew agreed with this point and proposed that Corporate Communications produce a comprehensive report on Clyde progress.

Director of Corporate Planning and Policy

On a similar point, Ms Nijjar wondered how all the consultations would be considered by respondees. Ms Renfrew confirmed that each had a different target audience and it was for that reason that they had been set up individually rather than as one consultation with various strands. She assured the NHS Board that each consultation would be constructed according to its target group.

Director of Corporate Planning and Policy

Mr Carson referred to the Independent Living Fund particularly as the criteria had been changed recently raising the ceiling of allowance per week. He asked what impact this may have on the NHS and Ms Renfrew advised that the Director of Rehabilitation and Assessment would clarify this.

Director of Rehabilitation and Assessment

DECIDED:

- That the proposed changes to specialist physical disability inpatient services be noted.

- That the NHS Board move to formal public consultation on the future service location.

Director of Corporate Planning and Policy

11. VALE OF LEVEN HOSPITAL : CHANGES TO UNSCHEDULED MEDICAL CARE

A report of the Director of Corporate Planning and Policy [Board Paper No 08/6] asked the NHS Board to reconsider its decision not to publically consult on the transfer of the unscheduled medical care service from the Vale of Leven and, subject to approving that recommendation, discuss how the initial findings on community engagement could inform a consultation process.

Ms Renfrew reminded the NHS Board of the outcome of the Independent Scrutiny Panel (ISP) process in relation to unscheduled medical care at the Vale of Leven Hospital. At the 18 December 2007 meeting, the NHS Board noted the Independent Scrutiny Panel's clinical conclusions supported the Board's proposal to transfer the unscheduled medical care service from the Vale of Leven Hospital. At that time, the NHS Board further noted that the Panel's recommendations on options for consultation did not sit comfortably with those clinical conclusions which, in effect, left only one sustainable option – the transfer of the service. The NHS Board had, therefore, concluded that on the basis of safety and clinical governance, plans should be developed, as soon as possible, to transfer unscheduled admission services, in a planned and managed way, from the Vale of Leven Hospital to the Royal Alexandra Hospital, with a process of community engagement rather than formal public consultation.

The NHS Board had also recognised the continuing issues for the local community and agreed to review, at its January 2008 meeting, proposals for that detailed programme of local community engagement to explain why these changes were necessary. Local staff would be fully involved in the development of the planning and community engagement process.

ACTION BY

Since the December 2007 NHS Board meeting the NHS Board Chairman and Chief Executive had had a number of face to face and written exchanges with the Scottish Government about the above points and the Cabinet Secretary had asked the NHS Board to re-engage with the Independent Scrutiny Panel to discuss its clinical conclusions and how these related to their recommendations for consultation. Mr Divers and Dr Cowan were scheduled to meet the Independent Scrutiny Panel Members on 28 January for this purpose and to draw this engagement to a positive conclusion, with the minimal possible delay, given the real issues about the present service arrangements.

In addition, the Cabinet Secretary had instructed the NHS Board to conduct a formal public consultation and, on that basis this paper asked the NHS Board to reconsider its previous decision that public consultation was not appropriate where there was only one viable option particularly in light of the concerns about the current service. This meant that rather than a process of community engagement during which the plan to transfer the service was implemented, the NHS Board would accept that, after public consultation, Ministerial approval would be required for such a transfer to take place and that the action to achieve a planned and managed transfer would be delayed.

During a detailed discussion the following points were made:

- Mr Williamson asked whether the NHS Board was now being asked to consult on all options and where did responsibility for safety now lie? Mr Divers clarified by explaining that it was his intention to discuss on 28 January, with the Independent Scrutiny Panel Members, the contradiction between their clear clinical conclusions that there was no sustainable option to continue to provide the service at the Vale and their recommendations for consultation on a number of options. In terms of clinical safety for service provision at the Vale of Leven, responsibility rested with him as Accountable Officer.

- It was recognised that the NHS Board's December 2007 conclusion had not changed in terms of its accountability and clinical governance responsibilities – what had changed was the Cabinet Secretary's intervention instructing the NHS Board to conduct a formal public consultation. Mr P Hamilton was concerned that the NHS Board would then be consulting while there were service issues which required transfer as soon as possible, and only one option for the future provision of this service. That had not previously happened in his time as a NHS Board Member. Ms Renfrew noted the difficulty caused by the contradictions between the Independent Scrutiny Panel's endorsement of the clinical elements of the NHS Board's proposals and its recommendation to consult on options which were at odds with those clinical conclusions.

- Ms Dhir asked what the public consultation process would involve and how it differed from the earlier proposal of public engagement. Ms Renfrew explained that a public consultation would normally last around twelve weeks and during the consultation period, the NHS Board would not make any decisions or commence any changes in service. A public engagement process, on the other hand, would have allowed the NHS Board to go ahead and make decisions and associated changes during the period whilst engaging with communities.

- Mr McLaughlin agreed that the NHS Board remained concerned around sustainability and safety of services at the Vale of Leven but to gain public confidence could not see how the NHS Board could ignore an instruction from the Cabinet Secretary. Councillor MacKay agreed with this point.

ACTION BY

- Dr Cowan referred to the relative nature of clinical safety and explained why it was difficult to define. Dr Cowan confirmed that the NHS Board's Clinical Governance Committee had looked at risk and governance arrangements at the Vale of Leven and a series of service changes had been made to ensure the service was as safe as possible. He added that the service currently being provided at the Vale of Leven Hospital did not match that which was being provided in other parts of NHSGGC and, as the Independent Scrutiny Panel report confirmed, there were significant problems in providing emergency medical care in the absence of intensive therapy and emergency surgery, which could not be provided at the Vale of Leven. The service could continue to be sustained for a few more months and he would advise the Board that medical receiving was as safe as it could be, but was provided at the Vale of Leven Hospital in circumstances which had serious limitations.

- Ms Renfrew noted the importance of the continuing concern that there were serious limitations in providing the service at the Vale of Leven. Mr Divers believed that, on balance, the NHS Board should press to move to a short, formal consultation period while recognising that the service did not meet standards elsewhere and it was unsustainable.

- Mr Cleland thought it important to understand the logic in the Independent Scrutiny Panel recommendations. Mr Divers explained that the aim of the meeting with Panel Members was to understand the Panel's clinical conclusions and how these related to their recommendations for consultation. He expected all four Panel Members to be in attendance at the meeting along with himself and Dr Cowan. The outcome of this meeting, therefore, would be helpful in framing the consultation material.

- Councillor Handibode referred to Dr Cowan's earlier comments and quoted from the Independent Scrutiny Panel report that service at the Vale of Leven Hospital was currently "significantly less than ideal". He was concerned that any formal consultation period would mean that the NHS Board would be required to sustain this service, with its acknowledged serious limitations, during that period and he could not support that position.

- Mr Sime wondered what was required of the NHS Board in terms of its Standing Orders and whether the NHS Board had to comply with this instruction from the Cabinet Secretary, particularly when it was contrary to medical advice. Mr J Hamilton confirmed that the Standing Orders were silent on this point.

- The NHS Board considered the challenges for staff at the Vale of Leven. Dr Cowan commended staff at the Vale of Leven for doing as good a job as they could within existing limitations with no intensive care or surgical services. Although staff were under continuing pressure and scrutiny, at the moment, particularly with ongoing locum arrangements, he was of the opinion that services could be sustained for a short consultation period. Mr Divers agreed with this point.

- Mr Williamson recognised that if the service was sustained for a consultation period, the Cabinet Secretary would then be required to consider the outcome from the consultation and, thereafter, approve, or otherwise, the NHS Board's final recommendation. He noted there was no definitive timescale on this additional period required by the Cabinet Secretary to come to a decision. Mrs Smith echoed this point and as Chairman of the NHS Board's Audit Committee recognised the role in managing risks associated with sustaining this service.

ACTION BY

- Mr Calderwood explained that operationally, the NHS Board wished to re-align medical receiving away from the Vale of Leven Hospital. This had to be undertaken as quickly as possible and in a planned way. Although the end point would remain the same, there was now a consultation process which the NHS Board must go through. Dr Kapasi emphasised that at the December NHS Board meeting an important part of the consideration was safety.

- Councillor Mackay stated that the Cabinet Secretary required the NHS Board to undertake consultation and the NHS Board should proceed with that. However, he wondered about the timescale of that process and what would happen if any of the risk factors changed significantly during that time. He was advised that if this happened the Medical Director would bring these to the Chief Executive's and NHS Board's attention for further consideration.

- On the issue of public consultation, whilst the process was different from public engagement, the information and process described in the NHS Board paper were noted as providing a good basis for consultation material. The issue of the ambulance services would be explored in a meaningful way in the consultation document and the experiences of patients at the Royal Alexandra Hospital would be considered.

- Mr Robertson explained that the Cabinet Secretary was clear that a public consultation must be undertaken. He agreed with earlier points that the outcome of the meeting with Independent Scrutiny Panel Members would be helpful in shaping the consultation. He recognised the NHS Board Members' need for reassurance regarding timescales but as the ultimate decision lay with the Cabinet Secretary, the NHS Board itself was not in control of this. He assured Members that following the meeting with Independent Scrutiny Panel Members, an update report would be made available to them. Mr Robertson also agreed to write to the Cabinet Secretary to report the Board's continuing concerns about the delay in transferring the service, to raise the possibility of a shorter consultation period and to highlight the need for a rapid decision at the end of that process. **Chairman**

DECIDED:

- That the NHS Board's decision not to publically consult on the transfer of the unscheduled medical care service from the Vale of Leven be reconsidered and a period of formal public consultation be initiated as soon as possible Councillor Handibode recorded his dissent from the decision. **Director of Corporate Planning and Policy**

- That the consultation materials be framed around the initial findings on the community engagement process. **Director of Corporate Planning and Policy**

12. THE FUTURE ARRANGEMENTS FOR PRIMARY AND COMMUNITY SERVICES IN CAMBUSLANG/RUTHERGLEN AND THE NORTHERN CORRIDOR

A report of the Director of Corporate Planning and Policy, the Director, South Lanarkshire CHP and the Director, North Lanarkshire CHP [Board Paper No 08/07] asked the NHS Board to accept the conclusion and next steps outlined and formally agree to the further transfer of responsibility from NHSGGC to NHS Lanarkshire of the directly employed staff and GMS contracts within the Cambuslang/Rutherglen locality and receive a formal report in regard to the Northern Corridor with North Lanarkshire Council at its February 2008 meeting.

ACTION BY

Mr Lawrie reminded the NHS Board of the background and rationale for considering change in the Cambuslang/Rutherglen and Northern Corridor areas. Discussions had been ongoing since August 2007 when both Boards of NHS Greater Glasgow and Clyde and NHS Lanarkshire received a paper from the South Lanarkshire CHP outlining proposals for the future arrangement of the primary and community care services within the Cambuslang/Rutherglen locality. Since then, work had been (and continued to be) undertaken to more closely align both areas into the CHPs (Cambuslang/Rutherglen into the South Lanarkshire CHP and the Northern Corridor into the North Lanarkshire CHP). Both NHS Boards had a duty to ensure that the CHPs were working optimally and that they were best able to look after the health of the people of Cambuslang/Rutherglen and the Northern Corridor now and into the future.

In terms of the Northern Corridor, a further paper would be presented to the NHS Board in February 2008 as there was a need to create a formal engagement process within the Northern Corridor to build on the informal engagement already taking place.

In relation to the Cambuslang/Rutherglen locality, it was considered that a way forward which would alleviate a number of issues would be to formally transfer responsibility for the locality from NHSGGC to the South Lanarkshire CHP, operating within NHS Lanarkshire.

Mr Lawrie led the NHS Board through what these changes would mean emphasising that the physical areas of Cambuslang and Rutherglen would still remain within the NHSGGC boundary, however, the full financial and operational responsibility for staff and independent contractors (where this was legally possible) would pass to the South Lanarkshire CHP which would fully manage the services on NHSGGC's behalf as an integrated part of the wider CHP. This would allow the locality to work more efficiently, sharing best practice more easily and communicate with ease with the rest of South Lanarkshire CHP.

Mr Lawrie summarised the discussion and consultation that had taken place with stakeholders, staff and patient groups to progress this. For Rutherglen and Cambuslang, the breadth of meetings that had been held was felt to fulfil the requirements set out by the NHS Boards in August 2007. The meetings with staff were planned to be undertaken through the Locality Partnership Group. It was made clear, however, that NHSGGC procedures were required to be adopted and, as such, further meetings in line with the procedures were organised. For the Northern Corridor, the meetings to date provided a platform for the circulation of a formal discussion paper and a report to the February NHS Board for decision.

Mr Lawrie highlighted some of the issues that had come up during discussion and consultation and provided an overview of the transfer options discussed with staff. The proposals that were initially put forward were aimed very clearly at improving upon the governance, planning and accountability framework under which the localities in question operated. Clear legal advice had been taken in regard to the actions that could and could not be taken by the NHS Boards in terms of further transfer of responsibility. The outcome of this was that both directly employed staff and GMS contracts could be transferred but that Community Pharmacy, General Dental Practitioners and Optometrists could not. As such, it was considered that the transfer of both staff contracts and GMS contracts to the South Lanarkshire CHP was legal and that the majority of concerns and issues raised by these groups could be addressed and accommodated.

ACTION BY

Dr Colville raised several operational questions to which Mr Lawrie responded. He was reassured that NHSGGC could intervene if it was dissatisfied with the performance of South Lanarkshire CHP or if it considered the new regime was not operating effectively. It was apparent that GP contractors would be covered by Lanarkshire's Local Medical Committee (LMC) under these proposals while there may be informal arrangements with the Glasgow LMC.

Councillor Handibode welcomed the proposals and viewed them as a blue-print for future arrangements.

In response to a question from Dr Benton, Ms Renfrew confirmed that there was no requirement for a public consultation exercise as there were no proposals to change services. Discussions had, however, taken place with the Patient Partnership Forum (PPF).

In response to a question from Mr Sime, Ms Renfrew confirmed that reassurances had been given to staff and staff representatives that, in the event of the transfer being approved, appropriate processes would be put in place to allow staff to have a better appreciation of the changes for them both collectively and individually, reflecting the transfer option deemed appropriate. This would include the establishment of an implementation team to facilitate effective communication with all members of staff.

DECIDED:

- That the conclusions and next steps outlined in the report be accepted. — **Director of Corporate Planning and Policy**
- That the further transfer of responsibility from NHS Greater Glasgow and Clyde to NHS Lanarkshire of the directly employed staff and GMS contracts within the Cambuslang/Rutherglen locality be formally agreed. — **Director of Corporate Planning and Policy**
- That a formal report in regard to the Northern Corridor be received at the NHS Board's February 2008 meeting. — **Director of Corporate Planning and Policy**

13. INDEPENDENT SCRUTINY CONSULTATION : DISCUSSION PAPER

A report of the Director of Corporate Planning and Policy [Board Paper No 08/8] asked the NHS Board to discuss the issues outlined to respond to consultation on independent scrutiny.

Ms Renfrew referred to the Scottish Government's consultation on the introduction of independent scrutiny. She provided a basis for the NHS Board to discuss its response with the underlying assumption that independent scrutiny would be introduced and, therefore, the focus was on examining and commenting on the options and rationale presented, considering the position with independent scrutiny elsewhere in the UK and articulating a model which might be the most effective way forward.

ACTION BY

Ms Renfrew presented key extracts from the consultation paper and provided a commentary. She summarised the Scottish Government's three options – decision conference, a scrutiny body or an expert panel. In considering the consultation paper, the NHS Board could reflect upon its own experiences so far and those from England. At headline level, the NHS Board would suggest that any independent scrutiny panel should offer advice to the Cabinet Secretary on making decisions on controversial proposals – and that the focus of that advice should be on the decisions made by the NHS Board at the end of the planning, review and public consultation processes, given the Scottish Health Council's role on public consultation and engagement.

From the point of view of governance and wider credibility, it was important that any panel processes commanded the confidence of NHS staff and NHS Board Members as well as of the general public and wider professional interests and were genuinely independent. The NHS Board noted the potential conflicts between public and community opinion and patient interests which should be reflected in the consultation response.

The issues which would be considered by scrutiny panels would be complex and a consistent approach would be required. The volume of scrutiny required was likely to be small and, therefore, it was suggested that a single standing panel, of a mix of interests be appointed by the Cabinet Secretary. The NHS Board would suggest that to tailor its approach to particular issues and local circumstances, the panel should commission an appropriate group of expert advisers on clinical, financial and planning issues. Furthermore, the panel would need a properly organised and appropriately senior secretariat.

In response to a question regarding the model in England, Ms Renfrew confirmed that the consultation document made very little reference to this. She advised, however, that Local Authorities in England had the power to review and scrutinise on matters relating to the planning, provision and operation of local health services. Local Authority scrutiny committees must be consulted on any proposed substantial reconfiguration or development of health service provision for their area. These scrutiny committees could refer matters failing to be resolved locally to the Secretary of State for Health. Where such a referral was made, the Secretary of State may ask the independent reconfiguration panel to advise on the issue. This panel had a standing group of members appointed from across the UK, the membership of which was a mix of voluntary sector, lay members, councillors, NHS managers and clinicians. The Secretary of State received the panel's advice on arriving at decisions.

Ms Dhir sought inclusion in the NHS Board's response of re-emphasising that NHS Boards were accountable to the Scottish Government and that with the introduction of independent scrutiny, the role of Non-Executive Members should be reflected upon.

Councillor MacKay expressed a different view on the trigger point for scrutiny. He agreed with the consultation proposal that independent scrutiny would take place at the early stages of the decision making process and before full public consultation. It was the NHS Board's view, however, that triggering independent scrutiny at this point was not at the early stages of the decision making process but generally at the end of a long process of pre-engagement and planning.

DECIDED:

- That the issues outlined in the NHS Board paper to respond to consultation on independent scrutiny and NHS Board Members' comments be noted and reflected into the response to consultation. **Director of Corporate Planning and Policy**

ACTION BY

14. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2007

A report of the Director of Finance [Board Paper No 08/09] asked the NHS Board to note the financial performance for the 8 months of the financial year and comments relating to performance against the 2007/08 Financial Plan.

Mr Griffin confirmed that at 30 November 2007, NHSGGC was reporting a close to break-even position against a year to date budget of £1,701m. This confirmed that the NHS Board continued to manage its expenditure levels in line with budget.

In 2006/07, the NHS Board reported a revenue surplus of £27.3m which arose as a result of the impact of property disposals that were concluded during 2006/07. It was agreed with the Scottish Government Health Department (SGHD) that this one off benefit could be carried forward into 2007/08 and deployed on a non recurring basis to support the achievement of national waiting time targets by the required date of 31 December 2007. At this stage of 2007/08, the year end outturn was forecast to be a break even position against the overall revenue budget.

During November/December, a detailed mid-year financial review was undertaken covering all service areas and funding sources – Mr Griffin summarised this mid-year review which confirmed that it was reasonable to forecast that the NHS Board would manage its total expenditure within available resources in 2007/08. In relation to Clyde there was a residual funding gap of £8m in 2007/08. It was reasonable to anticipate that this could be resolved with the Scottish Government Health Department following the same approach as in 2006/07 and that during January/February, joint discussions would continue with SGHD colleagues to finalise an agreement for achieving this.

NOTED

15. CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES : 18 DECEMBER 2007

The Minutes of the Clinical Governance Committee meeting held on 18 December 2007 [CGC(M)07/5] were noted.

Dr Cowan confirmed that as of 5 February 2008, the Clinical Governance Committee would have completed a range of presentations from all Directorates and Partnerships on their respective clinical governance arrangements.

NOTED

16. PHARMACY PRACTICES COMMITTEE MEETING MINUTES : 13 DECEMBER 2007 AND 14 DECEMBER 2007

The Minutes of the Pharmacy Practices Committee (PPC) meetings held on 13 December 2007 [PPC(M)07/21] and 14 December 2007 [PPC(M)07/22]were noted.

NOTED

ACTION BY

17. AREA CLINICAL FORUM MEETING MINUTES : 13 DECEMBER 2007

The Minutes of the Area Clinical Forum meeting held on 13 December 2007 [ACF(M)07/7] were noted.

NOTED

The meeting ended at 12.30 pm

NHSGG&C(M)08/2
Minutes: 18 - 33

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 19 February 2008 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE
Mr R Cleland
Councillor J Coleman
Dr D Colville
Dr B Cowan
Ms R Crocket
Mr P Daniels OBE
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Dr M Kapasi MBE
Councillor J McIlwee
Councillor D MacKay
Mr G McLaughlin
Mrs R K Nijjar
Ms A Paul
Mr D Sime
Mrs E Smith
Councillor A Stewart
Mrs A Stewart MBE
Mr B Williamson
Councillor D Yates

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Ms S Gordon	..	Secretariat Manager
Mr P Gallagher	..	Director of Finance (Acute)
Mr J C Hamilton	..	Head of Board Administration
Mr D Leese	..	Director, Renfrewshire CHP (to Minute No 26)
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy

B Y I N V I T A T I O N

Ms G Leslie	..	Chair, Area Optometric Committee

ACTION BY

18. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Professor D Barlow, Mr G Carson, Dr L de Caestecker, Councillor J Handibode, Mrs J Murray and Councillor I Robertson.

19. CHAIR'S REPORT

(i) Mr Robertson reported that Ms R Crocket had been re-appointed to the NHS Board by the Cabinet Secretary for Health and Wellbeing as the Board's Nurse Director.

ACTION BY

(ii) Mr Robertson had met with Professor Andrew Hamnet (University of Strathclyde) and Professor Pamela Gillies (Glasgow Caledonian University) to pursue areas of joint work and common interest. There was a willingness to continue this series of meetings.

(iii) The official opening of the Beatson West of Scotland Cancer Centre took place on 1 February 2008 by the First Minister and Cabinet Secretary for Health and Wellbeing. This provided an opportunity to meet patients, staff and carers as well as see the facilities and excellent standard of services being provided.

(iv) A number of Non Executive Members had taken up the opportunity to visit the new Gartnavel Royal Hospital site. This was making good progress and represented a £19m investment for NHSGGC. It would create a modern and innovative mental health hospital with ground breaking design and layout.

(v) After seeking nominees for the position of Vice Chair, Mr Robertson reported that he had had some expressions of interest and would meet with these NHS Board Members over the next few days to discuss the role further and, thereafter, report back to the NHS Board at its meeting scheduled for April 2008. **Chairman**

NOTED

20. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers and Mr Robertson attended, on 24 January 2008, the inaugural lecture by Professor C Tannahill at Glasgow Caledonian University. This further forged the strategic alliance arrangements with higher educational establishments and explored areas of future development.

(ii) Mr Divers had been accompanied by Ms C Renfrew and Mr N Hunter to a cross-party briefing on drug and alcohol services across NHSGGC. Twelve MSPs had participated in this briefing and discussed addiction services across the piece as well as future additional investment in alcohol services and the update of the alcohol strategy. This briefing had been well received and encouraged Mr Divers to think of other topics for future discussion with cross-party groups of MSPs – this would be explored further. **Chief Executive**

(iii) Mr Divers had met with colleagues from the Scottish Government Health Department (SGHD) to discuss the NHS Board's Mid-Year Review. A broad range of topics were covered including the NHS Board's overall performance, financial performance, forward look and HEAT targets for 2008/09. A detailed note of the outcomes of this meeting would be provided at the next Performance Review Group (PRG) meeting. **Chief Executive**

NOTED

21. MINUTES

On the motion of Mr P Hamilton, seconded by Mrs E Smith, the Minutes of the meeting of the NHS Board held on Tuesday, 19 February 2008 [NHSGG&C(M)08/1] were approved as an accurate record and signed by the Chairman subject to the following amendments:

- Page 12, item 11, first bullet point, second line, delete the word "define" and insert the word "quantify".

- Page 12, item 11, fifth bullet point, third line, delete "particularly when it was contrary to medical advice".

NOTED

22. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted.

(ii) In relation to Minute 12 – Page 15 – first paragraph – The future arrangements for Primary and Community Services in Cambuslang/Rutherglen and the Northern Corridor – Dr Colville advised that it was apparent that GP Contractors would be covered by Lanarkshire's Local Medical Committee (LMC) under the future arrangements for primary and community services in Cambuslang/Rutherglen (although there may be informal arrangements with Glasgow's LMC). He reported that the Glasgow LMC was consulting with British Medical Association (BMA) lawyers to seek a legal opinion on who should represent the Camglen GPs. Ms Renfrew commented that any dispute over which LMC (Glasgow or Lanarkshire) would represent GPs would get picked up by the Implementation Group.

NOTED

23. NEW SOUTH-SIDE HOSPITAL, NEW CHILDREN'S HOSPITAL AND NEW LABORATORY BUILD – APPROVAL OF THE OUTLINE BUSINESS CASE

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/10] asked the NHS Board to receive the detailed key points in the Outline Business Case (OBC) for the New Southside Hospital, New Children's Hospital and New Laboratory Build, and to approve the OBC.

Ms Byrne reported that the draft OBC had already been submitted to the Capital Investment Group (CIG) for consideration in late February 2008 subject to approval at the NHS Board meeting. Following approval by the CIG, it would be submitted to the Cabinet for consideration in March.

Ms Byrne provided the NHS Board with an update on the progress of the New Southside Hospital, New Children's Hospital and New Laboratory Build project, in particular, the preferred option, expected benefits, proposed procurement route, value for money and affordability. She described the strategy behind the plans and outlined that, on completion of the development in 2014, the NHS Board would be able to enact the following:

- Inpatient services in the Victoria Infirmary to transfer to the new development thus vacating the Victoria Infirmary site.

- Inpatient services at the Mansion House Unit to transfer allowing closure of the Unit. (A number of inpatient beds would have already transferred to the new Victoria Hospital).

- Inpatient services housed in outdated buildings on the Southern General site to be relocated.

- Transfer of Accident and Emergency services and associated beds at the Western Infirmary enabling closure of the Western Infirmary.

By 2014, following some major refurbishment and new build works within the existing estate at Glasgow Royal Infirmary and Gartnavel General Hospital, sufficient capacity would be created, following the opening of the new South Glasgow Hospital, to allow the three site inpatient configuration of adult services to be implemented, therefore, also allowing the rationalisation of the inpatient services from Stobhill to Glasgow Royal Infirmary by no later than 2014.

Ms Byrne led the NHS Board through the expected benefits from the new adult and children's hospital, the bed modelling to inform the size and scope of the new adult and children's hospital and the design of an integrated building. She confirmed that, throughout the process to reach the stage of Outline Business Case, comments had been taken on board from the Scottish Government Health Directorate (SGHD) and NHS Board colleagues to emphasise the benefits to patients, families and staff as well as the community engagement work that had been undertaken alongside work with other stakeholders and academic partners.

The estimated timetable to achieve the appropriate approvals to enable the project to move to the procurement stage was summarised as follows:

Final OBC to Board	19 February 2008
Final OBC considered at CIG	26 February 2008
CIG Approval	End of February 2008
Submit to Cabinet	Early March 2008
Final OBC Approval	End of March 2008
FBC Submission	Summer 2010
Construction Starts	Autumn 2010
Completion – Children's Hospital	Beginning 2013
Completion – Acute Hospital	Summer 2014

Mr McLaughlin referred to the many occasions that this project had been discussed with NHS Board Members at seminars, a result of which was that Members felt comfortable with the iterative process. He commended the Planning Teams involved for making complex details easily understandable and in achieving support from staff and other stakeholders.

Mr Griffin led the NHS Board through the extract on the financial consequences of the OBC. He summarised the ten year financial plan which projected the NHS Board's anticipated sources of additional revenue funds and likely expenditure commitments over the forthcoming ten year period, including the additional cost commitment associated with developing new adult and children's hospitals on the Southern General site. He summarised the key assumptions including the assumption that a general funding uplift of 3.1% per annum would be received. In terms of appraising the risks, three key areas of risks were identified as follows:

- Funding uplift reduced below 3.1%.
- Annual general pay uplift exceeded 2%.
- 2% cost savings target was not achievable in 2009/2010 to 2010/2011.

Mr Griffin set out the capital consequences and explained that this reflected the NHS Board's preferred option for procuring the new adult and children's hospitals by public capital.

Mr Sime was satisfied that the financial plan provided strong assurance to the NHS Board and recorded that the proposals provided not only an excellent future for NHSGGC's health service but regionally and nationally. He welcomed the public funding and was aware that there would be much work to do with trade unions and professional organisations as the proposals progressed particularly in relation to meeting the challenge of the timetable and cost savings. Mr Divers reported that such a series of meetings had already commenced with the Area Partnership Forum being briefed and their commitment being received to continue with a programme of meetings over the months ahead.

ACTION BY

Mrs Smith welcomed the openness and transparency of the documents particularly in outlining the key risks and assumptions that had been well documented and defined. She welcomed the governance arrangements incorporated into the proposals and Mr Divers recorded that a similar developmental process to that with the NHS Board had taken place with SGHD colleagues to ensure that the profiling of both revenue and capital had been tracked through with them.

In response to a question from Mr Daniels, Mr Griffin confirmed that provision for inflation had been included.

DECIDED:

- That the detailed key points in the Outline Business Case for the new Southside Hospital, new Children's Hospital and new Laboratory build be received.

- That the Outline Business Case be approved. **Director of Acute Services Strategy, Implementation and Planning**

24. WINTER PLAN 2007/08

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/11] asked the NHS Board to receive an update on Winter Planning 2007/08 including a progress report on how the plan worked over the extended festive period and into the New Year.

Ms Byrne explained that the 2007/08 Winter Plan for NHSGGC was developed, for the first time, on a single system basis, involving partners from across the organisation who were involved in the delivery of services. Across the system, there had been a significant level of integrated planning and working with the Winter Plan Group meeting monthly since summer 2007. In addition, an Executive Group had been established which had met frequently since November and continued to meet. Overall, it was considered that the Plan had worked effectively and Ms Byrne summarised comments received from the main partners including, Primary Care, NHS24, GEMS/Clyde Primary Care Emergency Service, Scottish Ambulance Service, Acute Services, Dental Services and Community Pharmacy. Although it was unanimously agreed that the Plan had worked well, it was acknowledged that the festive period in 2007/08 had not had a four day holiday period and that this had assisted.

For the first time, daily reporting had been provided by the Health Information and Technology Directorate. Although generally well received, it had been agreed that more work was needed for future years and this would be considered in more detail at the review meeting scheduled for April. In line with the Scottish Government's requirements, a weekly exception report had been sent to the Scottish Government Health Directorate (SGHD) providing information regarding ward closures, outbreaks etc. In addition, the Communications Department contacted SGHD as necessary to inform them of any exceptional circumstances.

Dr Colville commended the plan and, in particular, the new "phone-in service" between GPs and Consultants. Although this was introduced as part of the Winter Plan, he hoped that it would be extended as it had proved successful and saved, on occasions, acute admissions and outpatient appointments proving valuable to GPs, patients and the acute sector.

ACTION BY

DECIDED:

That the update on the Winter Plan 2007/08, including a progress report on how the plan worked over the extended festive period and into the New Year be received.

25. NORTH LANARKSHIRE COMMUNITY HEALTH PARTNERSHIP : THE FUTURE ARRANGEMENTS FOR PRIMARY AND COMMUNITY SERVICES NORTHERN CORRIDOR

A report of the Director, North Lanarkshire CHP and Director of Corporate Planning and Policy NHSGGC [Board Paper No 08/12] was submitted outlining proposals for the future management of primary and community services within the Northern Corridor (Stepps, Chryston and Moodiesburn).

Ms Renfrew addressed the rationale for the current organisational configuration and explained why change was required and what this would mean. She summarised the potential impact of these changes for patients, staff and primary care contractors explaining that it was important that the Northern Corridor did not become an island between the two NHS Boards starved of the ability to further develop primary care services for the benefit of its population.

She confirmed that the Board of NHS Lanarkshire (NHSL) would also consider the proposed future arrangements and, following both NHS Boards' approval, a Joint Implementation Team, chaired by the CHP Directors and with input from GPs and staff side organisations from the Northern Corridor and Camglen localities, HR, Finance, IM&T and Performance Management, would be established. This would ensure that the transfer was undertaken within legal boundaries, set at a pace consistent with organisational change policies and within a framework which ensured that appropriate re-assurances were delivered.

The Implementation Team would be tasked with establishing the process for legal transfer, establishing the detailed arrangements to both support staff and also GMS contracts from a NHSGGC to a NHSL environment. In addition, this team would establish the service level agreement between the two NHS Boards. A final report prior to transfer would be provided to the NHS Board and its associated committees to ensure that appropriate governance and process had been followed and that clear accountability was in place.

Ms Paul commended the proposals and supported the planning and implementation arrangements. This was echoed by Mr Daniels.

DECIDED:

(i) That the conclusions and next steps outlined in the report and further transfer of responsibilities from NHSGGC to NHS Lanarkshire of the directly employed staff and GMS contracts within the Northern Corridor be formally agreed. **Director, North Lanarkshire CHP/Director of Corporate Planning and Policy**

(ii) That the transfer be undertaken at an appropriate juncture in the financial year 2008/09 and by no later than March 2009 be agreed. **Director, North Lanarkshire CHP/Director of Corporate Planning and Policy**

ACTION BY

(iii) That an Implementation Team be established to formally manage the process of transfer within the agreed parameters set above. **Director, North Lanarkshire CHP/Director of Corporate Planning and Policy**

26. FULL BUSINESS CASE – RENFREW HEALTH AND SOCIAL WORK CENTRE

A report of the Director, Renfrewshire CHP [Board Paper No 08/13] asked the NHS Board to approve the Full Business Case (FBC) for Renfrew Health and Social Work Centre for submission to the Scottish Government Capital Investment Group (CIG).

Mr Leese explained that a Council owned site had been identified as suitable for a new purpose built multi-purpose facility for health and social work services. Agreement had been reached between the Scottish Government and NHSGGC that £15m (around 50%) of the funding for this development and that of the Barrhead Health Centre would be provided by the Scottish Government, with the remaining funds being provided through NHSGGC's capital programme.

This agreement was reached on the understanding that both NHSGGC and the Scottish Government would seek to replace the Greater Glasgow funding from the proceeds of the future sale of property within the former Clyde area.

The OBC was approved by the Performance Review Group at its meeting in January 2007. The FBC identified an NHS capital expenditure requirement of £15.5m, the same figure as was identified in the OBC. The expected additional revenue requirement had fallen from £1.2m to £1.1m from the OBC to the FBC. Provision for both revenue and capital implications of the development had been made within NHSGGC's financial plans.

Mr Leese outlined the timetable for this development which would see service transfer complete by the end of 2009. The FBC was scheduled for consideration by the Scottish Government Capital Investment Group at its meeting on 26 February 2008.

Mrs Nijjar cited this as an excellent example of planning for an integrated care service and commended Mr Leese and his team for taking this forward working jointly with the Local Authority. Councillor MacKay echoed this view and highlighted the community involvement work that had taken place throughout to ensure that the community was well informed of the proposals and the first class facility that the model would provide.

In response to a question from Mr McLaughlin, Mr Leese confirmed that the plans were compliant with the design action plan and that their requirements had been considered throughout the design phases. In this regard, flood prevention and drainage had also been considered and the building would be set higher than road level.

DECIDED:

That the Full Business Case for Renfrew Health and Social Work Centre for submission to the Scottish Government Capital Investment Group be approved. **Director, Renfrewshire CHP**

ACTION BY

27. CLYDE SERVICES UPDATE

Ms Renfrew reported on the following developments since the January NHS Board meeting:

- Consultation on services provided at Johnstone Hospital – this public consultation had been launched on Monday 18 February 2008 and would end on Monday 5 May 2008. The consultation was on the proposal to close Johnstone Hospital and transfer the specialist inpatient services it provided to more modern accommodation, probably in either Paisley or Renfrew. This would also ensure that, rather than being cared for in large wards with multi-bedded rooms, patients would have single bedrooms with ensuite facilities which offered greater privacy, dignity and respect. During the consultation, specific meetings would be arranged for local staff and for families and carers of existing patients. A public meeting would also take place on 13 March 2008 at the Glynhill Hotel in Renfrew.

- Consultation on Clyde Inpatient Disability Services – this public consultation had been launched on Monday 18 February 2008 and would end on 5 May 2008. The consultation was on new arrangements for providing specialist inpatient physical disability services as well as community based care for adults living in Renfrewshire and Inverclyde. Currently thirty-one people annually from Inverclyde and Renfrewshire were admitted to sixteen beds at Islay Cottage, Merchiston Hospital near Johnstone. A further sixty-five people a year were admitted to eight assessment and rehabilitation beds at Inverclyde Royal Hospital. The plan was to close Islay Cottage on the Merchiston Hospital site and provide continuing care services in Ward 53 at the Southern General. Four unused beds at the Southern General would also be opened to provide additional rehabilitation and assessment capacity. Future inpatient disability services for Clyde would, therefore, be provided at the Southern General and Inverclyde Royal Hospital.

- Consultation on Clyde Maternity Services Review – it was expected that this would be launched by the middle of March 2008.

- Consultation on Modernising Clyde Mental Health Services – it was anticipated that this would be launched by the end of February 2008.

- Consultation on Changes to Unscheduled Medical Care, Vale of Leven Hospital – a meeting had taken place with the Independent Scrutiny Panel Members on 8 February 2008 to discuss how best to proceed with this consultation. Their feedback was awaited but, in the meantime, material was being drafted, in liaison with the Scottish Health Council, in anticipation of the consultation and the timeframe.

NOTED

28. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer, Acute Services Division [Board Paper No 08/14] asked the NHS Board to note progress against the national targets as at the end of December 2007.

Mr Calderwood summarised progress across the single system towards achieving waiting time and other access targets set by the Scottish Government Health Department commonly known as HEAT Targets. Mr Calderwood highlighted the following:

- By the end of 2007, no inpatient/day case had to wait more than 18 weeks from a decision to undertake treatment to the start of that treatment – the Division had maintained this position since December 2006 and would continue to achieve the 18 week maximum wait in the next period.

- By the end of 2007 Availability Status Codes (ASCs) would be abolished – this target had been achieved. Although 771 patients were unavailable for treatment at the end of December 2007, it was because they were medically unfit or unavailable for personal/social reasons and within the terms of the guidance these patients transferred over on to the New Ways system on 1 January 2008.

- By the end of 2007 no patient would wait more than 18 weeks from GP referral to an outpatient appointment – this target was achieved.

- By the end of 2007 the maximum length of time from arrival to admission, discharge or transfer for 98% of Accident and Emergency patients would be four hours – this target was achieved.

- By the end of 2007 the maximum time from referral to completion of treatment for cataract surgery would be 18 weeks – this target was achieved.

- By the end of 2007 the maximum time from admission following fracture to a specialist hip surgery unit for surgery would be 24 hours for 98% of patients – there had been a partial failure of this target as 96.4% of patients were treated within 24 hours. A full escalation policy had now been implemented to ensure that swift action was taken to avoid a recurrence of this problem.

- Continue to deliver and sustain all cancer targets and guarantees (breast surgery from urgent referral to diagnosis and treatment within one month. Lung, bowel, ovarian, head and neck, haematology, gynaecology, skin, prostate, bladder, paediatric from urgent referral to diagnosis and treatment within two months) – there had been a partial failure meeting this target although significant progress had been made. Weekly monitoring was now in place across the specialties for patients with cancer.

- By the end of July 2007 the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy would be nine weeks, with a further target of this to be embedded within the overall eighteen week outpatient wait by the end of 2007 – although mostly achieved, some problems were identified with patients waiting for a MRI Scan at the Royal Alexandra Hospital – by the end of January 2008 no patients were waiting beyond the 9 week guarantee.

- By the end of 2007 the maximum wait from GP referral through a rapid access chest pain clinic or equivalent, to cardiac intervention would be sixteen weeks. Heart treatment would be provided within sixteen weeks of the outpatient appointment with a heart specialist and where that specialist had recommended treatment – this target had been achieved.

ACTION BY

- The number of people waiting over six weeks for discharge to a more appropriate care setting would be reduced by 50% from April 2006 to April 2007 and to zero by April 2008. The number of patients delayed in short stay beds would be reduced by 50% from April 2006 to April 2007 and to zero by April 2008 - Mr Calderwood identified some capacity shortages particularly in West Glasgow and West Dunbartonshire, however, the main focus of activity was working with patients and their families to accept interim moves to available placements whilst awaiting final choice of care setting.

- Stroke – 80% of fast track referrals to Stroke/TIA clinics to be seen within fourteen days. 80% of stroke patients to have CT or MRI scan within 48 hours of admission – modest progress had been made with regard to this target and changes in clinic arrangements had been implemented on each site to ensure improvements.

In response to a question from Mr P Hamilton, Mr Calderwood explained that it was too early to say how the New Ways system was operating as it was only implemented on 1 January 2008. Data was awaited for analysis.

NOTED

29. PHARMACY PRACTICES COMMITTEE MEETING MINUTES : 10 JANUARY 2008

The Minutes of the Pharmacy Practices Committee meeting held on 10 January 2008 [PPC(M)2007/23]were noted.

NOTED

30. GLASGOW CENTRE FOR POPULATION HEALTH MEETING MINUTES : 11 DECEMBER 2007

The Minutes of the Glasgow Centre for Population Health meeting held on 11 December 2007 [GCPHMB(M)07/4] were noted.

NOTED

31. MENTAL HEALTH PARTNERSHIP COMMITTEE MEETING MINUTES : 8 NOVEMBER 2007

The Minutes of the Mental Health Partnership Committee meeting held on 8 November 2007 [2007/01] were noted.

NOTED

32. PERFORMANCE REVIEW GROUP MEETING MINUTES : 14 JANUARY 2008

The Minutes of the Performance Review Group meeting held on 14 January 2008 [PRG(M)08/1] were noted.

NOTED

ACTION BY

33. INVOLVING PEOPLE COMMITTEE MEETING MINUTES : 13 NOVEMBER 2007 AND 5 FEBRUARY 2008

The Involving People Committee meeting Minutes from 13 November 2007 and 5 February 2008 [Board Paper No 08/15] were noted.

NOTED

The meeting ended at 11.30 am

Board paper No 08/10

Board Paper

19th February 2008

New Southside Hospital, New Children's Hospital and New Laboratory Build – Approval of the Outline Business Case

Helen Byrne, Director of Acute Services, Strategy, Implementation and Planning

RECOMMENDATION

Board Members are asked to receive this paper which details the key points in the Outline Business Case (OBC) for the New Southside Hospital, New Children's Hospital and New Laboratory Build, and to approve the Outline Business Case (OBC).

It should be noted that the OBC has been submitted to the Capital Investment Group (CIG), for consideration in late February 2008. Following approval, it will be submitted to the Cabinet for consideration in March.

Copies of the Outline Business Case are available on request.

1.0 PURPOSE OF THE PAPER

The purpose of the paper is to provide the Board with an update on the progress of the New Southside Hospital, New Children's Hospital and New Laboratory Build project. In particular: the preferred option; expected benefits; proposed procurement route; value for money; and affordability. In more detail, the content of the paper is laid out as follows:

- Section 2 – describes the reasons behind the plans for the new adult and new children's hospitals and the new laboratory build.
- Section 3 outlines the expected benefits of the scheme.
- Section 4 describes the bed modelling undertaken in scoping the new hospitals.
- Section 5 Outlines the Greenfield site Option
- Section 6 details the proposed position of the new hospitals and new lab build on the southern site and links to existing buildings.
- Section 7 reviews the options of whether the hospitals should be built separately or together as an integrated building.
- Section 8 outlines the work undertaken in developing the Public Sector Comparator (PSC) of the new hospitals and the outcome of the design option appraisal.
- Section 9 explores the other associated works planned for the Southern site in support of the new hospitals and new lab build.
- Section 10 details the options for delivering the new hospitals, new lab build and associated works.

- Section 11 describes the financial modelling; appraisal of procurement methods, and Value for Money and affordability issues: **TO FOLLOW**.
- Sections 12 outlines the timescales for the project.
- Section 13 provides an update of the planning application progress.
- Section 14 outlines the community engagement work.
- Section 15 details the outcome of the Gateway Review.

2.0 STRATEGY BEHIND THE PLANS TO BUILD A NEW ADULT AND NEW CHILDREN'S HOSPITAL AND NEW LABORATORY FACILITY

The following describes the strategy behind plans to build a new adult hospital, new children's hospital and new laboratory facility in the south of the city.

2.1 New South Glasgow Hospital

The new adult hospital constitutes the second phase of the Acute Services Review. The main goal of the Acute Services Review is to address the mounting pressures to change the way in which services are delivered by reducing the number of acute sites across Glasgow and investing in fit for purpose facilities. In more detail the New South Glasgow Hospital development is the major part of the plans to reconfigure services by reducing the adult inpatient sites from the current six hospital sites to three, by the time the new hospital opens in 2014. Two sites, Glasgow Royal and the Southern General, will have A&E and trauma facilities. The third inpatient hospital will be Gartnavel General. These acute sites will be supported by the two new build Ambulatory Care Hospitals.

The Acute Services Strategy was envisaged being implemented in four distinct phases. The first stage is well underway and involves the two new build Ambulatory Care Hospitals currently under construction at the site adjacent to the Victoria Infirmary and Stobhill Hospital site, the centralisation of cancer services at the new Beatson West of Scotland Cancer Centre built at Gartnavel General Hospital and the development of the West of Scotland Heart and Lung Services at the Golden Jubilee National Hospital, replacing facilities currently at the Western and Glasgow Royal Infirmaries.

This first phase of investment, which represents almost £350m of capital investment, will see these new facilities commissioned over the period late 2007 to summer 2009, which will result in not only significant modernisation of our healthcare facilities and creation of single centres of excellence but will result in 4 of our major adult hospital sites operating below capacity.

Phase 2 of the Acute Strategy sees the development of the new South Glasgow Hospital campus which not only sees the single biggest phase of modernisation and rationalisation of our adult clinical services, but incorporates the creation of a new Children's Hospital for the Greater Glasgow and West of Scotland populations and the completion of our Maternity Services modernisation.

On completion of the development of the new adult hospital in 2014, the Board will be able to enact the following:

- inpatient services in the Victoria Infirmary to transfer to the new development thus vacating the Victoria Infirmary site;
- inpatient services at the Mansion House Unit (MHU) to transfer allowing closure of the MHU;
- inpatient services housed in outdated buildings on the southern site to be relocated;
- transfer of Accident and Emergency services and associated beds at the Western Infirmary enabling closure of the Western Infirmary.

By 2014, following some major refurbishment and new build works within the existing estate at Glasgow Royal Infirmary and Gartnavel General Hospital, sufficient capacity will be created, following the opening of the new South Glasgow Hospital, to allow the 3 site inpatient configuration of adult services to be implemented, therefore also allowing the rationalisation of the inpatient services from Stobhill to Glasgow Royal Infirmary by no later than 2014.

Phase 3 of the Acute Services Strategy sees the major redevelopment and modernisation of the Glasgow Royal Infirmary campus and this work will be developed with a view to being brought forward for funding consideration in the period beyond 2015 followed by the final phase, which would see the redevelopment and modernisation of the retained adult inpatient services required on the Gartnavel General Hospital campus undertaken.

2.2 The New Children's Hospital

The Queen Mother's Hospital (QMH) is currently one of three maternity units within Greater Glasgow, the others being located at the Southern General Hospital (SGH) and the Glasgow Royal Infirmary (the Princess Royal Maternity Hospital - PRMH).

In April 2004, the NHSGG Board considered proposals for the modernisation of maternity services. It was agreed that maternity services should be provided from two sites, i.e. from the maternity unit at the SGH and from the Princess Royal Maternity Hospital (PRMH). The Queen Mothers Hospital (QMH) would therefore close. Closure is planned following completion of the refurbishment and new build development at the maternity wing on the SGH site, during 2009/10.

On reviewing the NHS Board's decision, in September 2004 the then Minister for Health also took account of views that the "gold standard" in delivering care in the future would be achieved by providing adult acute services, maternity services and specialist children's hospital services together on a single site. As part of his decision on maternity services, the Minister announced the provision of a New Children's Hospital for Glasgow and a commitment to make available £100 million of Treasury capital to fund this. The Minister also announced that an Expert Clinical Advisory Group would be established.

Following a review of possible options the Clinical Advisory Group led by Professor Calder, identified the Southern General campus as the preferred site to offer the 'gold standard' triple co-location allowing the children's hospital to be co-located with both maternity and adult services.

The New Children's hospital forms part of the second phase of the Acute Services Review Strategy and will allow transfer of services into the new purpose built hospital in 2013 with subsequent closure of the Royal Hospital for Sick Children.

2.3 New Laboratory Build

A review of laboratory services was carried out to identify the optimum configuration of laboratory services in Glasgow to support the Acute Services Strategy. The preferred option involves: centralising the majority of laboratory services into two main sites at Glasgow Royal and the Southern site; consolidating immunology, tissue typing, stem cell lab work and all other laboratory services associated with leukaemia research and Haemato-oncology onto the Gartnavel site co-location with the West of Scotland Cancer Centre; and finally centralising pathology and genetics services onto a single site near the Southern Campus.

A new build 5,200 square metre laboratory facility is planned for the Southern General site housing haematology, biochemistry and mortuary services. The laboratory will be located alongside the new hospitals linked via an underground tunnel.

The new build will support the New Adult and Children's Hospitals and other services south of the city. The planned model for the new laboratory development will be one of high volume processing of tests with use of automation and up-to-date integrated IT systems with extended day and 24/7 working to reflect the new patient care models.

3.0 EXPECTED BENEFITS OF THE SCHEME

The following summarises expected benefits from the New Adult and Children's Hospital:

3.1 Clinical Benefits

- The new adult hospital will facilitate the consolidation of adult inpatient services onto 3 sites.
- The new children's hospital will achieve triple co-location of the children's, maternity and adult services.

Both the new adult and children's hospitals will enable:

- Provision of high quality services which are timely, accessible and consistently available by providing local access to core medical and surgical services and consolidating specialist and tertiary services on fewer sites within the city.
- Modern, fit for purpose facilities with investment in high tech equipment and IT and attention to design and landscaping will improve the patients overall care and experience.
- Reduced waiting times for treatment through the provision of more efficient services increasing clinical capacity by investment in IT, the concentration of clinical teams onto fewer sites, optimising departmental and functional relationships and improving access to diagnostic services.
- Access to highly specialised services provided by skilled staff facilitated through the centralisation of services.

- Rapid one stop services through high volume processing of diagnostic tests and an extended working day to fit in with new models of care.

- Protection of elective workload from disruption by emergencies thereby improving the efficiency of the service and reducing the number of cancellations.

- Enhanced staff skills and knowledge through improved retention and recruitment due to a radically better working environment

- Enhanced University links through co-location of an academic centre with the new hospitals on the Southern General Campus. This will enhance teaching, and research and play a significant role in attracting and retaining high quality staff in all disciplines

3.2 Social and Economic Benefits

In addition to the clinical benefits listed above, the new hospitals will also benefit the wider area.

A social economic benefits analysis was carried out by SQW Consultants, funded by NHS Greater Glasgow NHS in partnership with a number of other contributors including Scottish Enterprise and Glasgow City Council.

The analysis looked at the potential impact on the immediate area around the Southern General site, the wider city of Glasgow and the Glasgow Metropolitan City Region. The analysis identified potential benefits within the following categories: economic, human and social capital, knowledge (e.g. research and development) and place. In more detail, the projected benefits were as follows:

Economic Benefits

SQW have estimated that the future service configurations on the Southern General site will have a combined direct, indirect and induced economic impact of between £30 and £40 million on the South West Glasgow economy; between £110 and £140 million on the city economy and between £240 and £290 million on the Glasgow City region by 2012/13.

The capital projects commissioned to build the new hospitals site will support between 1,300 and 1,700 construction jobs per year for the six years between 2008/09 and 2013/14. Capital projects will support between 260 and 340 jobs per year in South West Glasgow and between 650 and 850 jobs per year in the rest of the City.

Human and Social Capital

The New South Glasgow Hospitals development has the potential to impact significantly on the local housing market. Housing providers need to consider future provision and incentives for NHS workers to relocate to South West Glasgow and retain future wage expenditure in the local economy.

Opportunities for training and employment are significant; partners are required to tailor existing and new training/ employment schemes to meet future labour demands created by the NSGH development.

There exist a number of opportunities that should be explored further with local partners to identify potential joint developments and/ or shared use of local community facilities. For example the potential to work collaboratively with local childcare providers to develop nursery/ childcare provision accessible to NHS staff.

Knowledge

The significance of the New Hospitals Campus as a catalyst to support collaboration between academic, public and private sector partners to realise opportunities in research and development, bio-medical and life sciences has yet to be fully articulated, although they are potentially significant at all three levels.

In conclusion the Southern General development is seen as a catalyst for wider social and regeneration activity contributing to the creation of higher aspirations for the physical development of the local area.

The analysis confirmed that potential benefits will only be achievable through joint working. Significant progress has been made in building effective partnerships, for example with Scottish Enterprise Glasgow, in exploiting the economic potential, and Glasgow City Council and SPT in identifying opportunities for improving transport and accessibility. In addition the project is already connected to local project structures including:

- Central Govan Action Plan Implementation Group
- South West Employability Strategic Group
- South West Physical Regeneration Group

The analysis reinforces the need to maintain this momentum. Therefore, in consolidating existing working relationships and developing synergies with partners planning processes and land investment programmes, NHS Greater Glasgow and Clyde will establish a New Hospitals Engagement Forum. This Forum's remit will be to provide strategic leadership, as a mechanism to inform and co-ordinate partner planning mechanisms, strategies and investment to bring added value to the new hospital projects.

4.0 BED MODELLING TO INFORM THE SIZE AND SCOPE OF THE NEW ADULT AND NEW CHILDREN'S HOSPITALS

Plans for the adult hospital include 1109 beds and an Emergency Department with the capacity for 110,000 attendances per annum. The hospital will function as an acute 'hot' site with an outpatient department serving the local population and a small medical day area. The surgical day case activity will take place at the New Victoria Ambulatory Care Hospital opening in 2009.

The 240 bedded children's hospital has Emergency Department capacity for 46,000 attendances per annum. The outpatients department will see an estimated 86,000 patients per annum and the day case facility an approximate 11,000 patients per annum.

The following section describes the bed modelling work which has informed the size and scope of the hospitals.

4.1 Benchmarking with peer hospitals

NHS Greater Glasgow and Clyde (GGC) appointed CHKS (an independent clinical activity analysis service which the Board has worked with for a number of years) to undertake bed modelling exercises for both acute adult services across Glasgow and acute children's services. The objectives of the reviews were to:

- Provide an objective assessment as to the current performance of the acute adult hospitals across Glasgow and the Royal Hospital for Sick Children (RHSC) services relative to their peers;
- Identify the potential for improving efficiency in terms of use of beds and patient throughput;

- Provide a projection of future demand in 2015;
- Provide an indication as to the potential bed requirements.

The bed models would also take cognisance of better clinical adjacencies, more efficient patient pathways, projected demographics and national policy adjustments.

4.2 Adult Bed Model

Within the core specialties covered by the Adult Bed Model there are currently 3047 inpatient beds across the 6 acute sites, against which the future bed provision is considered. The bed model for the Acute Services was updated during 2007 using the 2005/6 activity, and performance information to identify the currently proposed bed model supporting the outline business case. In considering the Adult Bed Model 2005/06 data was used to consider the efficiencies to be delivered through improved performance of Glasgow's Hospitals compared to the inner city peer hospitals across the UK.

By incrementally applying the impact of,

a) operating at best peer performance rates across each specialty;
b) achieving occupancy rates of 85% for elective work and 82% for non-elective activity;
c) growth in medicine and the impact of demographic changes;
d) performance targets on current and future activity such as waiting times;

the number of beds required for the core specialties for implementation of the Acute Services Review suggests a bed model of 2912. It should be noted that this number excludes beds associated with the following services: clinical haematology, oncology, plastic surgery and burns, oral surgery, neurosurgery, homeopathy, spinal and physical disabilities.

Modelling work has been undertaken to consider patient flows and the extant strategy position of single site specialties in relation to the number of beds required in light of the future plan of 3 inpatient sites for the city at Glasgow Royal Infirmary, Gartnavel General Hospital and at the Southern General Hospital site. In addition consideration has been given to potential developments to specialist services in Glasgow and changes to patient flows from Clyde in understanding the inpatient bed capacity required across the Glasgow Acute Hospitals. This work has informed the potential bed configuration that supports the 1109 new inpatient beds in the New South Glasgow Adult Hospital.

As this is an iterative process the bed modelling work will continue and will be updated with a 2006/7 benchmarked position, which is currently being explored to consider the further levels of efficiency that could be implemented. This will be ongoing in the months and years ahead to ensure a continued focus on efficiency.

4.3 Children's Bed Model

The existing Royal Hospital for Sick Children (RHSC) has 271 beds. In addition 8 paediatric neurosurgery beds are currently provided in the Institute of Neurosciences at the Southern General and will require to be incorporated into the New Children's

Hospital. At present young people aged 13-15 (inclusive) receive in-patient and outpatient secondary care in Greater Glasgow within adult hospital services. Following the recommendations of the Kerr Report "Building a Health Service Fit for the Future" (2005), and reinforced in "Better Health, Better Care", these patients will be cared for within the children's hospital services. It is estimated that this group of young people accesses on average 10 beds.

For the purposes of the bed modelling exercise CHKS classified 267 out of the 289 beds in Glasgow as inpatient beds. The CHKS base line was therefore **267** inpatient beds plus the day case/short stay and psychiatry beds.

By incrementally applying the impact of:

a) the predicted 11% fall in population base;

b) operating at best peer performance rates across each specialty;

c) achieving occupancy rates of 85% for elective work and 65% for non-elective work.

CHKS estimated that the total number of in-patient beds could fall from 267 to 195.

CHKS recommended a bed model of 245 beds – 195 inpatient beds supported by 50 beds reflecting a proportionate increase in day case, 23 hour and short stay beds sufficient to accommodate the required shift in practice in favour of ambulatory / short stay care models and the in-patient psychiatry unit.

Further consideration by the Clinical Advisory Board for the New Children's Hospital on additional efficiencies which might be achieved through further enhancement of occupancy levels, increased use of short stay beds and more efficient alignment of services, suggested a bed model of 240 beds.

Therefore the proposed bed model for the New Children's Hospital is 240 beds, although this will be reviewed throughout the planning stages of the project.

5.0 GREENFIELD SITE

It should be noted that, for the purposes of comparison for the Outline Business Case, the option of building the New Hospitals on a Greenfield site was revisited. This option was first explored in 2002 and was dismissed by the Health Board because of high cost. The outcome of 2007 work confirmed the 2002 findings in that this option will cost £1.8 billion and, in addition, require significant investment in the road and public transport infrastructure. The Greenfield Site option has therefore been discounted as outside the Board's affordability envelope but is included in the economic appraisal for purposes of comparison.

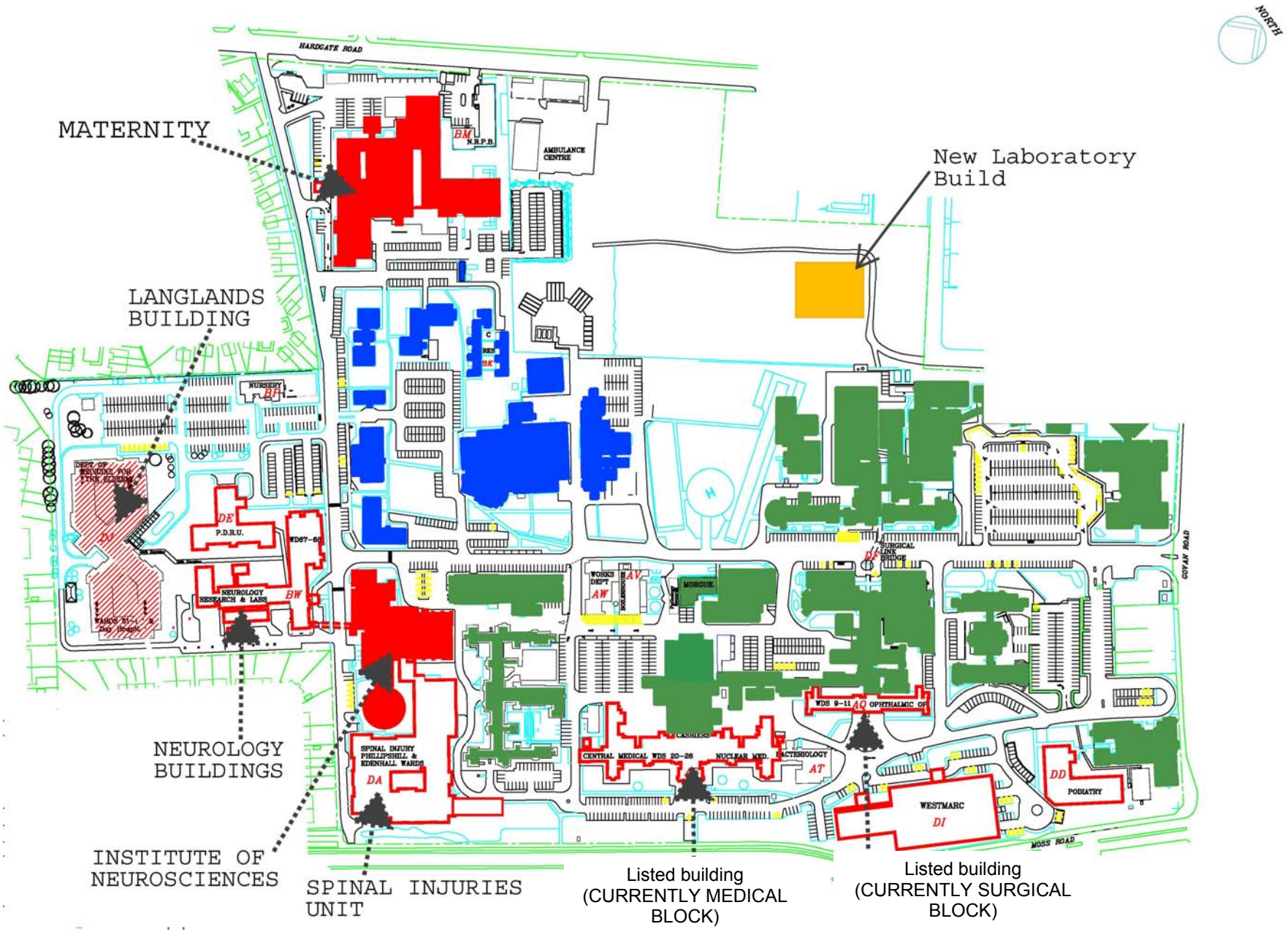
6.0 POSITION OF THE NEW HOSPITALS AND NEW LABORATORY FACILITY ON THE SOUTHERN SITE

One of the key criteria in considering the site of the new hospitals on the southern site is the need to physically link the new adult and new children's hospitals into both the maternity and neurosciences buildings to allow ready access to a full range of paediatric services for both foetus in utero and new born babies, and to enable pregnant mothers access to critical care and other acute services. The link between

Neurosciences Building and the New South Hospital will also allow rapid access for staff between both buildings, in particular the two critical care units

As described new build 5,200 square metre laboratory facility is planned for the Southern General site, this will be located alongside the new hospitals linked via an underground tunnel.

The site plan below shows the Southern General site as it is at present.


MATERNITY
New Laboratory Build
LANGLANDS BUILDING
NEUROLOGY BUILDINGS
INSTITUTE OF NEUROSCIENCES
SPINAL INJURIES UNIT
Listed building (CURRENTLY MEDICAL BLOCK)
Listed building (CURRENTLY SURGICAL BLOCK)
HARDGATE ROAD
AMBULANCE CENTRE
NURSERY
P.D.R.U.
NEUROLOGY RESEARCH & LABS
WORKS DEPT
MORGUE
SURGICAL LINK BRIDGE
SPINAL INJURY PHILLIPSHILL & KENNHALL WARDS
CENTRAL MEDICAL WDS 20-26
NUCLEAR MED.
BACTERIOLOGY
WDS 9-11 OPHTHALMIC
WESTMARC
PODIATRY
MOSS ROAD
GOVAN ROAD
NORTH

A51799939

The Neurosciences and Maternity buildings are blocked in red and can be seen situated at the top and bottom of the plan.

All the buildings marked in red will remain on the site long term. These include, amongst others, the aforementioned Maternity building and Institute of Neurosciences, the Spinal Injuries Unit, Neurology buildings, the front section of the Medical and Surgical Block and the Langlands building. These buildings are either relatively modern, subject to extensive refurbishment or are listed. The Langlands building is a 240 bedded PFI building completed in 2001 which houses services for care of the elderly, young physically disabled and dermatology.

The buildings marked in blue are within the site designated for the new Adult and Children's hospitals and the New Laboratory build. There is a comprehensive plan to re-locate all the services within the blue buildings to other locations to allow demolition and clearance of the site by 2010.

The buildings marked in green house patient services which will transfer the New South Hospital upon completion.

It is predicted that approximately 750,000 patients and carers/visitors per annum will be accessing the southern site. Discussions have been taking place with Glasgow City Council and SPT (Strathclyde Public Transport) to develop plans to route the planned fastlink connection for the south of the city through the southern site allowing a link from the city centre arriving every 10 minutes or so on to the site, with bus stops near the main entrances to the new adult and children's hospitals.

7.0 BUILD OPTIONS – SEPARATE HOSPITALS OR AN INTEGRATED BUILDING?

An option appraisal was undertaken, this looked at the benefits, risk, costs and deliverability of building the hospitals separately or as an integrated building. The preferred option identified was an integrated build to capitalise upon: the clinical synergies; the lower risk of fewer contractors on site; decreased complexity of interface issues between the two buildings with better patient flows and streamlining of processes; better deliverability and lower build and running costs due to operational synergies.

Various options for an integrated design were developed and appraised, these are described in Section 8.2.

8.0 DESIGN OF THE PREFERRED INTEGRATED OPTION FOR THE NEW ADULT AND CHILDREN'S HOSPITAL'S – DEVELOPMENT OF THE PUBLIC SECTOR COMPARATOR

A Public Sector Comparator (PSC) was developed to allow the clinical criteria (e.g. clinical adjacencies) and footprint allowance, (e.g. circulation space), to be tested and a budget cost to be established. The PSC was also used to check the building footprint was consistent with the size of the proposed site.

In developing the PSC several key criteria were considered, these were as follows:

- the critical clinical co-locations required within the new buildings;
- the need to maintain distinct and separate identities for both hospitals through separate public entrances and distinct public faces;

- the desirability of minimal travel times throughout the hospital;
- linkage into the new laboratory build;
- the requirements to link the new hospitals with the existing neurosciences and maternity buildings which sit at opposite ends of the site;
- the need to maintain existing hospital services during construction of the new development;
- desirability of future expansion space on the campus;
- impact of the new build upon surrounding neighbours.

8.1 Clinical Adjacencies

One of the areas identified for potential clinical synergies between the adult and children's hospital is Accident and Emergency, therefore the two A&E departments are required to be side by side. Both A&E departments also need ready access to diagnostics, theatres, critical care and acute assessment.

Another key co-location is the labour suite and obstetrics theatres to the neonatal unit which, in turn, needs to be co-located with the paediatric intensive care unit. Paediatric Intensive Care must be close to the theatres and radiology.

As previously described there must be a link into the Maternity and Neurosciences buildings.

These clinical co-locators set the parameters for the development of a 1:500 block layout of the new hospitals.

8.2 Preferred Design Option

Through consultation with technical Advisors and NHS stakeholders a range of 5 options were initially reviewed, those which did not meet the full design requirements were deselected. Designs which did meet the full brief were then subject to further review and refinement until 3 preferred options emerged. All 3 options:-

- facilitated the Board's preferred phasing strategy that allows the Adult and Children's hospital and labs to be built in one continuous operation.
- placed the New Children's Hospital on the west of the site where it can link to both the existing maternity block and the New Adult Acute Hospital to create the "Triple Gold Standard" of clinical care.
- provided a first floor link to the existing theatres and critical care areas in the Neurosciences Block.
- assumed the new fastlink service will pass through the site entering from Govan Road and exiting via new entrance onto Hardgate Road.
- had a common location for the new laboratory facility and Facilities Management block in the northwest corner site.

The three options ranged from a lower flatter building with 8 floors to a progressively taller, thinner building shape with 14 floors. An option appraisal was undertaken involving the design team, technical advisers, and NHS stakeholders.

The weighted criteria against which the options were scored included; access, achievement of departmental adjacencies, journey times, flexibility and future expansion abilities, external environment *(e.g. impact upon residencies, separate identities for children and adults hospital, landscape opportunities)*, internal environment *(e.g. views out of building for patient, public and staff, ease of way-finding clear segregation of visitors, patients and Facilities Management circulation) and* deliverability.

The appraisal process identified the tall thin building (14 storeys) as being the preferred configuration as it was most able to meet the above criteria.

Further work took place on the preferred option looking at alternative arrangements with regard to the positioning of entrances, and in particular the locations of the adult's and children's public emergency (walk in) entrances. The final result offered separate and distinct entrances to both hospitals, a shared blue light entrance, separate ambulatory entrances to the A&E departments of both hospitals, however, these were co-located in the event that if a user presented at the wrong entrance they could be redirected very quickly, without jeopardising patient care.

8.3 Schedules of Accommodation

Schedules of accommodation were developed with the Board's technical advisors and the Clinical Sub-Groups for both hospitals. These have been "clinically signed off" for the purposes of the OBC however, clinical re-design might lead to these being further developed during the next stage – albeit within the current cost envelope.

8.4 1:500 layouts

1:500 layouts have been designed for all hospital areas, and again these have been "clinically signed off" as meeting the clinical adjacencies described above (Clinical Adjacencies Section).

8.5 1:200 layouts

Ten key departments (5 in the new Children's Hospital and 5 in the new Adult Hospital) have been developed further to 1:200 designs. The key departments are A&E, Radiology, Wards, Critical Care and Public Concourse/Entrance for each hospital. These departments have been broadly agreed as meeting the clinical needs of the departments, and further refinement will continue in the next stage of the project.

8.6 Cost

The current PSC cost is based on the above work

9.0 OTHER ASSOCIATED WORKS

There are a series of smaller capital works associated with the new hospitals and new lab building, these being: development of two new multi-storey car parks; a new facility for clinical support services (such as offices, facilities management and clinical administration); and a 22 bedded extension onto the Westmarc rehabilitation centre for post acute amputee patients.

Glasgow University is proposing a new build academic centre near the new hospitals and an area of land on the Southern General Campus has been identified by the Health Board for this purpose.

A new combined Skills and Education Centre is also proposed, a possible location is on a site adjacent to the new hospitals.

10. OPTIONS FOR DELIVERING THE NEW SOUTH GLASGOW AND CHILDREN'S HOSPITALS, NEW LABORATORY AND ASSOCIATED WORKS ON THE SOUTHERN SITE

For the purposes of the Outline Business Case two options around the Southern General site have been developed, these are Option 1 and Option 1a. It should be noted that Option 1 is not affordable therefore the project was re-scoped to develop Option 1a.

The section below describes each option in detail.

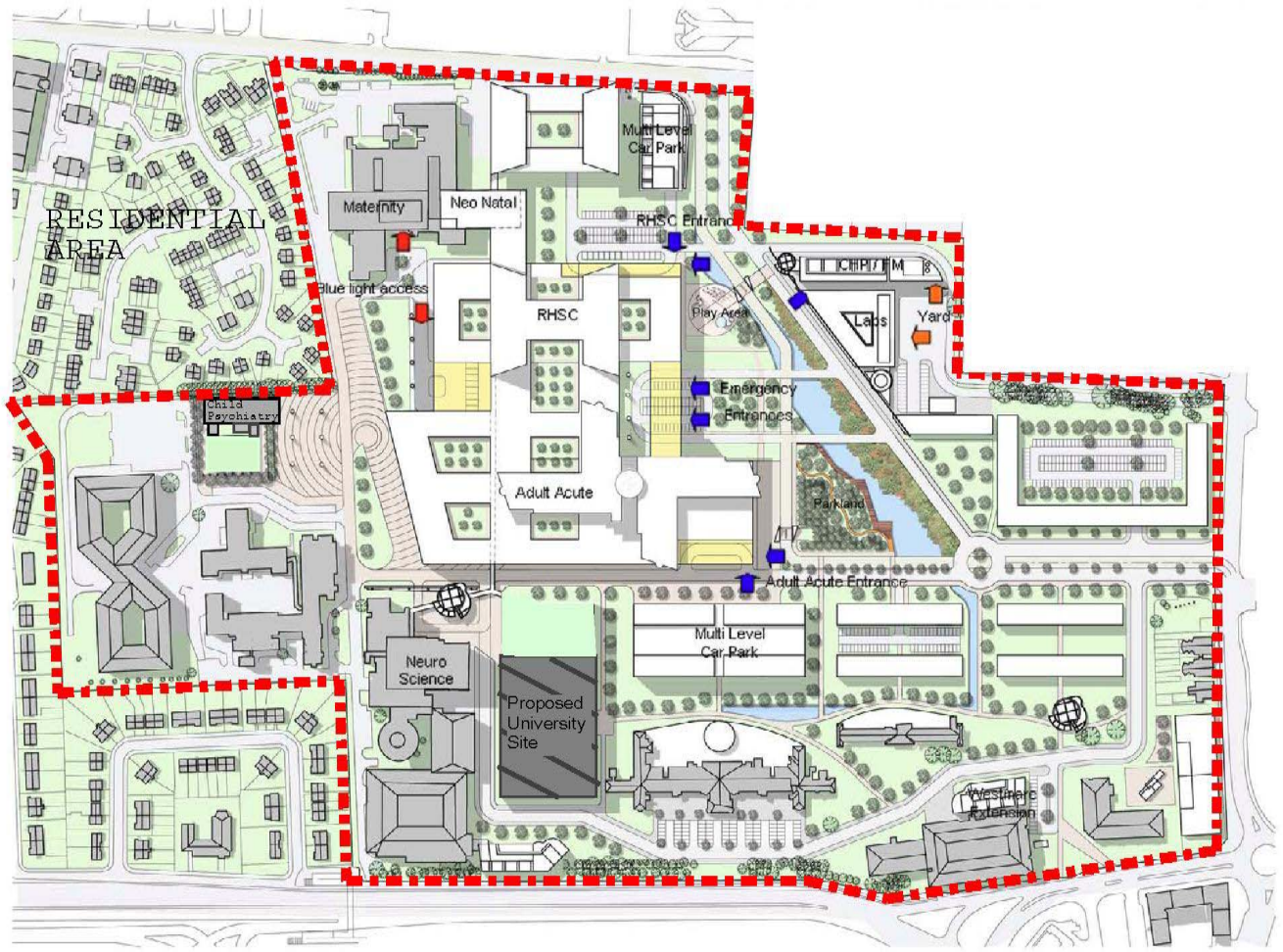
Option 1

Option 1 consists of an adult and children's hospital integrated within a single building to capitalise upon the clinical and facilities management synergies. The building will physically link into both the maternity and neurosciences buildings.

A new 17,000m^2 purpose built, multi-disciplinary laboratory facility is also planned. This will link into the new hospitals via an underground link and pneumatic tubes.

There are a series of smaller capital works associated with the new hospitals as previously described, to recap these are:- clearance of the build site, a number of enabling works, development of two new multi-storey car parks, a new build clinical support block, a new 22 bedded extension onto the Westmarc rehabilitation centre for post acute amputee patients and provision of land for a new academic centre.

An illustration of how the southern site will look under Option 1 is given below. The boundary of the Southern General Campus is marked by a dotted red line.



The following section describes Option 1a.

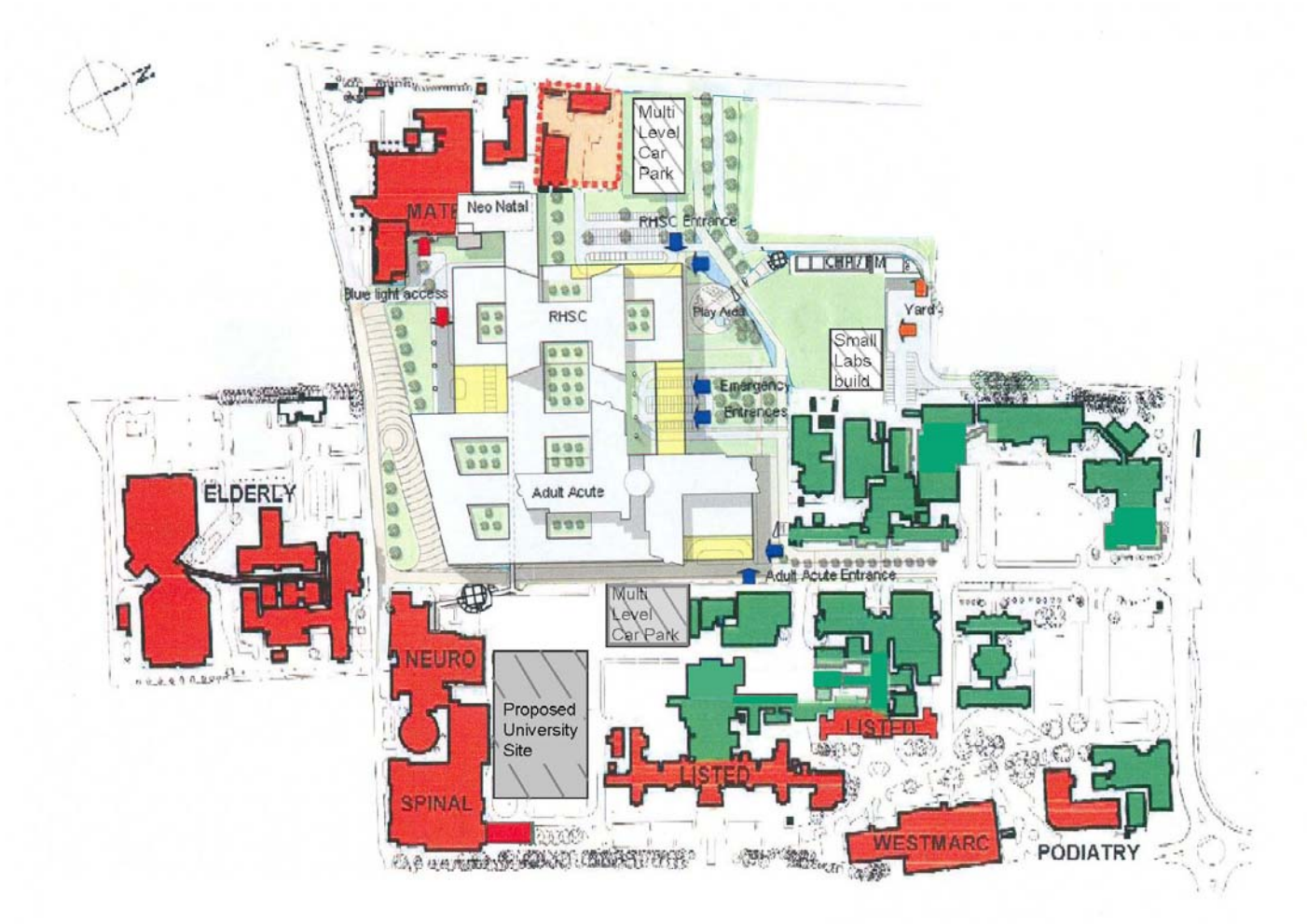
10.2 Option 1a

Option 1a consists of the planned integrated adult and children's hospital as described above. In this option however those associated works for which new builds were planned will now be incorporated into the existing estate.

In other words the green buildings shown in the plan in Section 6, which under Option 1 will be demolished will, under Option 1a be retained and reused.

In brief, the services which will be re-housed in the existing estate include, the 22 beds for post acute amputee patients and the facilities for clinical support (e.g. training, offices) and part of the laboratory services. There are plans for a smaller labs 5,200m^2 build housing haematology, microbiology and the mortuary services. There will also be laboratory accommodation (genetics and pathology) off site, provided by a lease agreement.

The diagram below illustrates the southern site under Option 1a.



An appraisal of Options 1 and 1a has taken place, this is described in the sections below.

11.0 APPRAISAL – FINANCIAL MODELLING, PROCUREMENT METHOD AND NON-FINANCIAL BENEFITS

TO FOLLOW

12.0 TIMETABLE TO COMPLETION OF OBC TO GOVERNMENT

The estimated timetable to achieve the appropriate approvals to enable the project to move to the delivery (procurement) stage are set out below along with the indicative timetable from approval of the Outline Business Case to completion of the integrated building. This includes the OJEU Process for the selection of the Technical Adviser, Design Team, and Contractors, and a construction period of 4 years to develop the New Adult and Children's Hospitals. It should be noted that the children's hospital is smaller and therefore will be completed before the adult hospital

Final OBC to Board	19th February 2008
Final OBC considered at CIG	26th February 2008
CIG approval	End of February 2008
Submit to Cabinet	Early March 2008
Final OBC Approval	End of March 2008
FBC Submission	Summer 2010
Construction Starts	Autumn 2010
Completion – Children's Hospital	Beginning 2013
Completion – Acute Hospital	Summer 2014

13.0 PLANNING APPLICATION

The Outline Planning Application was resubmitted to Glasgow City Council in April 2007. As part of the planning process NHSGG&C also submitted the Southern General Campus Plan in November 2006. Both the Council and NHSGG&C have worked together to enable the planning process to be as smooth and as timely as possible.

The application was considered at the Glasgow Planning Committee meeting held in January 2008 and received approval subject to specific conditions and the Section 75 legal agreements.

A key aspect of the outline application is the development of a transport plan which will be crucial in ensuring that the site operates as effectively as possible with the increase in staff, patients and visitors.

14.0 COMMUNITY ENGAGEMENT

NHS Greater Glasgow and Clyde established a Community Engagement team in 2002 to inform and involve patients and the public in the acute services strategy. Dedicated staff have been allocated to the new hospitals and an extensive programme of consultation with patients, carers, families is ongoing. Detailed work involving communities in Greater Govan and South West of Glasgow is also occurring. The team are working in partnership with both local and national organisations, such as Scottish Enterprise, to develop the full potential of the project for regenerating the wider area.

15.0 GATEWAY REVIEW

15.1 Background

The New South Glasgow Hospitals project is subject to Office of Government and Commerce (OGC) Gateway Review. Projects which are commission critical or deemed to be high risk projects are required to go through the six stages the OGC Gateway Review Process.

The review is an independent assessment of the robustness of the business case, that it meets business needs, is affordable, achievable with appropriate options explored and likely to achieve value for money. In doing this the review outcome highlights whether aspects of the project are red, amber or green (traffic light system).

- Red means that the project cannot proceed to the next milestone until the issues identified as identifies red are addressed.

- Amber means that the recommendations identified must be completed before the next Gateway Review stage.

- Green means that the project is in good shape but may benefit from uptake of any green recommendations to enhance the project.

The Southern General development has completed the Gateway Review Stage 1 which was carried out from 8th to 10th of January 2008. The review was carried out by a review team consisting of 2 Office of Government and Commerce Consultants and two senior technical NHS Scotland managers. During the three days of the review interviews were undertaken with 18 members of staff including clinicians, senior managers, project team, staff side representatives and finance colleagues.

This is the first time the Office of Government and Commerce Gateway Review has been used to assess a Scottish National Health Project although it has been used in non-health infrastructure projects.

15.2 Outcome of the Gateway Review

The Office of Governance and Commerce Gateway Review Team identified a number of positive aspects of the project, these are listed below.

The review confirms that:

1. The business case is
   - robust,
   - likely to be affordable,
   - achievable,
   - with the appropriate options explored,
   - and likely to achieve value for money.

2. The Project team is well established and has demonstrated an ability to draw on
   - internal skills and experience,
   - other projects throughout the UK.

3. There is considerable internal experience of major project delivery.

4. The Gateway reviewers were impressed by the consistent positive messages on the level of clinical engagement and commitment to new ways of working.

5. Project has maintained close communications with the Scottish Government at all levels.

6. There has been an open and inclusive approach to staff-side communication.

7. The project benefits from significant community engagement through the Community Engagement team.

8. It was acknowledged that Community Health and Care Partnerships are engaged.

9. It recognised the considerable effort expended in engaging with and developing support from the clinicians affected by the project.

Recommendations

The outcome of the Gateway Review was that there were no red recommendations hence the project may proceed to the Board and the Scottish Capital Investment Group with the Outline Business Case.

There were a number of amber recommendations which were identified as follows:-

Amber Recommendations:

- *The project team should ensure that the consequences of delays to decisions are made clear in all communications with the Scottish Government.*
- *The project team should take appropriate time to consider the full implications of a decision to adopt a traditional (design and build) procurement route.*
- *The project team should ensure the communications with staff-side representatives are fully understood.*
- *The project should produce a consolidated risk management register with regular review and reporting.*
- *The project team should review their draft plans for the project governance and management of the next phase.*

Green Recommendations - there was one recommendation here which will be fully adopted by the project team.

The five amber recommendations and one green recommendation will be addressed before the Gateway 2 review which is likely to take place in the summer. Immediate plans include:

- A workshop organised for mid February attended by the Boards legal and financial advisers supported by a number of technical advisers to determine the optimum conventional procurement model

- More detailed information and communication with staff side representations including continuing with internal meetings between the project managers and staff side, input into the Project Groups and involvement in how information should be more widely communicated to staff.

- Development of a fully consolidated risk register. This will amalgamate the current risk register held by the Project Team, the project risk management strategy and the technical risk register developed by the technical advisers which focuses specifically on building risks.

- The governance structures for the next phase of the project are being developed with draft proposals reflected in this document which will be subject to revision in line with the preferred Design and Build procurement model which will be identified through an option appraisal at the mid February workshop.

16.0 RECOMMENDATION

Board Members are asked to receive this paper which details the key points in the Outline Business Case (OBC) for the New Southside Hospital, New Children's Hospital and new Laboratory Build, and to approve the Outline Business Case (OBC).

It should be noted that the draft OBC has been submitted to the Capital Investment Group (CIG), for consideration in late February. Following approval, it will be submitted to the Cabinet for consideration in March.

Copies of the Outline Business Case will be available on request

9.3 Affordability of Proposal for New Adult and Children's Hospitals In context of NHSGG&C 10 year Financial Plan

9.3.1. Revenue Consequences

A top level 10 year financial plan is set out in table 1, with a more detailed summary provided in Section 9.4. This projects the Board's anticipated sources of additional revenue funds and likely expenditure commitments over the forthcoming 10 year period, including the additional cost commitment associated with developing new Adult and Children's Hospitals on the Southern General site.

Table 1 **Top Level Financial Plan : 2008/09 – 2017/18**

	08/09 £'M	09/10 £'M	10/11 £'M	11/12 £'M	12/13 £'M	13/14 £'M	14/15 £'M	15/16 £'M	16/17 £'M	17/18 £'M
Forecast additional funding	74.7	77.6	79.4	73.4	75.3	77.3	[redacted]	[redacted]	[redacted]	[redacted]
Forecast expenditure commitments										
Unavoidable expenditure growth / existing commitments	92.3	105.2	80.4	78.0	74.3	76.7	[redacted]	[redacted]	[redacted]	[redacted]
New adult/children's hospitals	-	-	-	-	-	13.0	[redacted]	-	-	-
General provision for new expenditure commitments	-	8.0	8.0	8.0	8.0	8.0	[redacted]	[redacted]	[redacted]	[redacted]
Total expenditure commitments	92.3	113.2	88.4	86.0	82.3	97.7	[redacted]	[redacted]	[redacted]	[redacted]
Cost Savings plan (excluding Clyde)	(26.2)	(27.0)	(33.4)	(12.0)	(13.1)	(10.0)	[redacted]	[redacted]	[redacted]	[redacted]
Projected in year surplus/deficit)	8.6	(8.6)	24.4	(0.6)	6.1	(10.4)	[redacted]	[redacted]	[redacted]	[redacted]
Recurring surplus/deficit) brought forward	-	8.6	-	24.4	23.8	29.9	[redacted]	[redacted]	[redacted]	[redacted]
Projected recurring surplus/deficit)	8.6	-	24.4	23.8	29.9	19.5	[redacted]	[redacted]	[redacted]	-
Provision for transitional costs associated with establishing new adult/children's hospitals	(8.6)	-	(24.4)	(23.8)	(29.9)	(8.5)	[redacted]	[redacted]	-	-
Projected net surplus/deficit	-	-	-	-	-	11.0	[redacted]	-	[redacted]	-

Notes :

1. Forecast additional funding includes additional funding related to general funding uplift and excludes anticipated funding related to specific ring fenced funding provisions set aside by SGHD. The only exception to this is the specific provision established in respect of "Access to Services" where it is assumed that NHSGG&C will receive £23m over the 3 year period to 2010/11. It is assumed that this funding will be fully committed during this period.

2. Unavoidable expenditure growth/existing commitments comprises anticipated additional expenditure on pays, prescribing, non-pays, capital charges, and all unavoidable service commitments already entered into for the period to 2017/18.

3. The financial plan anticipates that the existing funding deficit related to Clyde is managed to a recurring financial breakeven position over a 3 year period by a combination of recurring and non-recurring cost savings and transitional funding provided by SGHD. The financial summary contained

within Section 9.4 provides further details of the Clyde financial position, showing how this features within the context of the 10 year financial plan.

4. A high level cost savings summary is provided within Section 9.4. A summary of the key assumptions which underpin the financial projections shown in table 1, including an overview of the Board's financial strategy and appraisal of financial risk, is provided below.

i) **Key Assumptions**

- A general funding uplift of 3.1% per annum has been assumed. This is set below the recently announced general funding uplift for 2008/09 of 3.2% to allow for the potential impact which NRAC implementation might have on the Board's level of general funding uplift in future years.

- A general pay uplift of 2% per annum is provided for. This is reasonable in the light of current UK government policy and reflects the significant reduction in general funding uplift which will apply from 2008/09 onwards.

- An overall annual growth rate of 6% in prescribing costs is assumed across primary care and acute care. This allows for an average annual growth rate of 5.25% in primary care prescribing costs and 8.5% in acute prescribing costs, before cost savings and other cost containment measures. This gives an overall annual rate of growth of 6% and approximates closely to the average annual growth rate experienced in past years. This can be regarded as a reasonable basis for projecting future average cost growth over a future period which extends to 10 years.

- A provision of 1.5% per annum is made for the general growth of non-pay costs (excluding prescribing costs), with the exception of years 1-3 where a reduced provision equivalent to 1% is made. This reduced level of provision in years 1-3 years is linked with the development of a major cost savings programme by the Board aimed at driving out cash releasing savings of 2% per annum on an annual basis in line with Government targets. The sustainability of this level of provision over a period extending beyond 3 years is considered unlikely and so a higher level of provision is set for the years beyond 2010/11.

- The financial plan includes all known existing financial commitments related to clinical and other services. These are presented within the section "Existing Programme Commitments". The projected step up in revenue costs associated with the new Adult and Children's Hospitals is shown within this section. This shows a revenue cost commitment of £59.5m per annum, which is the revenue cost commitment associated with the new Adult and Children's Hospitals and those related capital schemes which are funded by the Board's general capital funding allocation. Provision is also made for prospective new service commitments for 2009/10 onwards at a level of £8m per annum, split 50:50 between Acute and Non Acute Services. This level of provision will require to cover all new changes/developments which the Board is required to commit to over a ten year period, including all those national, regional and local changes/developments/initiatives which are unable to be funded by the specific ring fenced funding allocations which SGHD establishes annually to fund service change/development. This represents, in broad terms, a reduction of approximately 20-30% on the equivalent level of provision in 2008/09, however

is considered realistic in the light of increasing levels of centrally managed ring fenced funding allocation, and a reduced level of general funding uplift. It should be noted that £8m per annum is regarded as a maximum provision, and may be scaled back, as required, to offset unforeseen cost pressures which may arise.

- The financial plan assumes that the Board will succeed in developing a cost savings plan which is capable of delivering 2% recurring cash releasing savings per annum during the period 2008/09 to 2010/11. This is in line with the SGHD targeted level of savings for the 3 year period to 2010/11. The cost savings plan includes restoring Clyde to a position of financial breakeven within the 3 year period.

  The Board is currently engaged in the process of developing a detailed cost savings plan for 2008/09, which is aimed at delivering £33m of recurrent cost savings, with the objective of completing this by June 2008. Thereafter the process of developing plans for 2009/10 and 2010/11 will commence. For the years beyond 2010/11, a reduced level of cost savings is assumed, with annual targets set within a range of 0.5% and 1% per annum. This comprises a number of specific areas of cost saving associated with implementation of those changes related to the establishment of new Adult and Children's Hospitals, supplemented by a general annual savings programme which equates to 0.4% per annum.

  At this stage, the Board has already identified [redacted] within its 10 year cost savings plan, specifically related to its existing Acute Services cost base, which is capable of being released to fund an anticipated step up in annual revenue cost of £59.5m associated with the establishment of New Adult and Children's Hospitals. During 2008/09, it will work at bridging the residual "gap" in parallel with developing an overall cost savings plan for 2009/10 and 2010/11.

(ii) **Overview of financial strategy**

The cornerstone of the Board's financial strategy, and the most significant individual feature of the Board's financial plan for the forthcoming 10 year period is its cost savings programme. This dominates its financial planning for the 3 year period to 2010/11, with cost savings/containment/reduction initiatives requiring in total to generate an average of £35m per annum. This level of saving is required in 2008/09 and 2009/10 to ensure that the step up in revenue cost associated with commissioning 2 ACAD's at Stobhill/Victoria in 2009/10 is fully funded, and continues into 2010/11 as the process of building up sufficient revenue funding capacity to fund the two new hospitals, in the lead up period to their commissioning, gets underway. The scale of additional cost commitment associated with the two new hospitals, £59.5m, demands that the volume of revenue funding which is required to pay for them, is built up over a number of years leading up to the commissioning of the hospitals…otherwise the Board would be unable to accommodate the running costs of these hospitals within the envelope of its available funds, while maintaining its commitment to achieve financial breakeven.

By commencing this process in 2010/11 and continuing to target further cost savings in the years beyond 2010/11 the Board's strategy is to amass an adequate pot of revenue funding which will match the additional cost commitment which the new hospitals will

bring. The financial plan shows the build up of this funding pot over a 5 year period commencing in 2010/11. By building up revenue funding in this way, the Board will also be able to generate in the interim period the level of transitional funding it requires on a non-recurrent basis to manage through the process of establishing the new hospitals. This is capable of being covered year on year by the build up of revenue funding identified within the financial plan. The deployment of these funds year on year will be managed within the context of the Board's financial plan so that it complies with its statutory requirement to contain expenditure within its overall revenue resource limit.

(iii) **Appraisal of Key Risks**

The key areas of risks are identified below:

(a) **Funding uplift reduces below 3.1%**

The 10 year plan projects that NRAC implementation will impact on the Board to the extent of restricting its annual general funding uplift by 0.1% or £2m per annum. This assumes that a measured approach will continue to be taken by SGHD to the implementation of formulaic changes affecting Health Board funding levels, mirroring the approach taken to the implementation of the Arbuthnott formula in recent years.

It is reasonable to assume that SGHD will continue to adopt this approach in order to avoid the potential for financially destabilising Health Boards, particularly at a time when the level of general funding uplift has been set at 3.2%, a much reduced level than in recent years. Accordingly, a 0.1% funding adjustment is provided for in preparing the Board's financial plan. This is equivalent to a cumulative reduction in revenue funding of £20m over a 10 year period, a significant reduction in funding availability in the context of an overall annual general funding uplift of 3.2%. On this basis it is not considered likely that SGHD would seek to implement a further restriction on funding unless the level of future general funding uplift exceeded 3.2%, in which case it is reasonable to assume that a proportionate approach would be taken.

(b) **Annual General Pay Uplift Exceeds 2%**

This is clearly a key area of risk. For any year where the rate of general pay uplift exceeded 2% by 0.5%, without any corresponding elevation of the rate of general funding uplift, a cost pressure of £6.5m - £7m would emerge.

The Board would seek to manage the potential impact of this within the context of its 10 year financial plan by scaling back the level of funding set aside for prospective new funding commitments. This would offer scope for containing an increased level of general pay uplift of up to 2.5% for 3 years out of the 10 covered by the 10 year plan. Beyond this, the Board would have little room for manoeuvre, however it is reasonable to assume that a more frequent incidence of annual general pay uplift exceeding 2% might lead to a review of approach on pay awards which is likely to produce an equivalent change to the level of general funding uplift so that its impact was cost neutral within the context of the Board's 10 year financial plan.

(c) **2% cost savings target is not achievable in 2009/10 – 2010/11**

The sustainability of a cost savings programme, aimed at generating recurring savings of 2% per annum, over an extended period of 3 years is also a key area of risk. It is recognised that the Board is entitled to include non-recurring cost savings and credit these towards the achievement of its 2% cost savings target over the 3 year period to 2010/11, however the generation of recurring cost savings during this period is necessary on two counts:

1) The requirement to fund the step up in recurring cost commitment associated with commissioning 2 new ACAD's in 2009/10.

2) The requirement to release sufficient funds to provide transitional funding cover during the lead up period to commissioning the new Adult and Children's Hospitals.

Nevertheless, there remains the possibility that a challenge of 2% recurring cost savings per annum proves unsustainable over a period of 3 years. In the event that this proves to be the case, with up to 50% of the target proving unachievable in years 2 and 3, the Board would face a "gap" of some [redacted] within its 10 year financial plan. It's strategy for addressing this would be as follows:

1) Spread the recurrent cost savings challenge across a longer period than 2009/10 and 2010/11.

2) Identify and plug in non-recurrent cost savings to "fill the gap" in each of 2009/10 and 2010/11, thereby securing the achievement of SGHD's cost savings target for each of these years and preserving the required level of transitional funding.

3) Reduce the level of provision set aside for prospective new programme commitments by up to [redacted] per annum over a 9 year period. This particular funding provision might also serve as form of contingency fund to cover for the potential of reduced/delayed achievement of cost savings target(s) in future years beyond 2010/11.

By following the above strategy, the Board would seek to manage the risk of its cost savings programme either not delivering the targeted level(s) of cost savings or experiencing delay(s) in achieving specific targets within individual years. Indeed, the same strategy would also be applied, albeit more comprehensively, in the event that the Board is confronted by a combination of pay pressure and delay to the achievability of its cost saving programme.

9.3.2 Capital Consequences

A top level capital plan is set out in table 2 below. This reflects the Board's preferred option for procuring its new Adult and Children's Hospitals, which envisages these being funded by Public Capital.

Table 2 **Top Level Capital Plan : 2008/09 – 2015/16**

	08/09 £'M	09/10 £'M	10/11 £'M	11/12 £'M	12/13 £'M	13/14 £'M	14/15 £'M	15/16 £'M	Total £'M
Forecast Capital Funding									
General funding allocation	97.6	97.6	97.6	97.6	97.6	97.6			-
Specific funding : medical equipment	9.0	9.0	9.0	9.0	9.0	9.0			
: other schemes	14.6	11.0	4.0	3.0					
SGHD agreed brokerage	26.9	11.4							
Total Capital Funding	**148.1**	**129.0**	**110.6**	**109.6**	**106.6**	**106.6**			
Allocation of Funding									
Committed schemes	112.4	80.8	47.2	14.0	9.0	9.0			
Provision for schemes not yet committed	5.8	13.3	0.5	40.9	37.6	30.5			
Provision for minor/local schemes	15.0	15.0	15.0	22.0	22.0	22.0			
New adult/children's hospitals – enabling Schemes	14.9	39.4	28.0	7.7	13.0	15.1		-	
Less : slippage/brokerage to be identified	-	(19.5)	(5.1)	-	-	-	-	-	
	148.1	129.0	85.6	84.6	81.6	76.6			
Residue of available capital funds	-	-	25.0	25.0	25.0	30.0		-	
Add : Capital Receipts	-	10.0	15.0	25.0	30.0	18.0			
: Endowment Funding	-	-	-	10.0	10.0	-	-	-	
NHSGG&C : total available funding	-	10.0	40.0	60.0	65.0	48.0			
Proposed supplementary allocation of capital funds by SGHD (specific allocation)	-	17.5	100.8	176.3	170.4	94.9			
	-	**27.5**	**140.8**	**236.3**	**235.4**	**142.9**		**-**	
Capital expenditure… new adult / children's hospitals	**-**	**27.5**	**140.8**	**236.3**	**235.4**	**142.9**		**-**	

The total capital funding requirement associated with the provision of the new Adult and Children's Hospitals is . It is planned that this will be funded by combining the following sources of capital funds to create the required funding pot:

		£'M	£'M
1.	Specific provision within Board's 10 year capital plan, set aside from annual general capital resource allocations.		
2.	Capital receipts generated from disposal of sites declared surplus		
3.	Allocation from Board's general endowment funds		
4.	SGHD – specific allocations of capital funds for a) children's hospital b) adult hospital		
	Total		====

The Board's capital plan provides for the capital contribution identified at (1) above to be made available out of its routine annual allocation of capital funding. This is projected to remain static over the 10 year period and so has been fixed at the 2008/09 level of per annum. It also provides for further expenditure on enabling (preparatory) schemes totalling to be funded from general capital funding….this is part of the expenditure provision shown within the "enabling schemes" category within table 2 above. Because of the heavy concentration of enabling (preparatory) schemes in the first 3 years of the plan, it has been necessary for the Board to restrict the amount(s) of capital which it is able to set aside for prospective new commitments in the first 3 years of the plan to an absolute minimum, with only £20m set aside for new schemes over a 3

year period. In addition, the amount which the Board routinely sets aside to cover minor local schemes/health and safety related schemes etc has been scaled back to £15m per annum, representing 70% of existing expenditure levels.

Even after having carried out such an aggressive process of prioritisation, the Board's capital plan is over-committed by almost £25m in total over an initial 3 year period, with the bulk of this arising in 2009/10. It is assumed that this can be managed through a combination of slippage/brokerage in conjunction with SGHD on a year by year basis, over the 3 year period. On the basis of previous experience and recognising the scale of the over-commitment, which equates to 8% of total available capital funding for the 3 year period, this should be both manageable and achievable.

It is further assumed that the Board is capable of generating [redacted] over a 10 year period from the disposal of sites declared surplus. This is based on a series of projections carried out by the Board's Property Advisors, based on the potential disposal of a wide range of sites including Victoria, Mansionhouse, Yorkhill, Gartnavel (part), Stobhill (part), Dykebar (part), Broomhill, among others, which are forecast to produce capital receipts during the forthcoming 10 year period. The wide range of sites which will become available for disposal during the forthcoming 10 year period provides the necessary level of reassurance that this level of targeted receipts can be achieved.

It is further assumed that the Board will be able to source up to £20m from its general endowment funds to contribute towards the capital costs of the new Adult and Children's Hospitals. With the total amount of endowment funds, currently standing at in excess of £80m, and over £30m within general endowment funds, this can be considered to be a realistic and reasonable assumption.

The final part of the capital funding package ….£551.7m …represents the specific allocation of funding which is sought from SGHD and which is an integral part of the proposal contained within this outline business case. If SGHD is able to approve this specific allocation of capital funding, in line with the timescales identified within the capital plan, this will provide the balance of capital funding which is required to make the provision of the new Adult and Children's Hospitals affordable within the context of the Board's capital plan.

SECTION 9.4.1 **10 YEAR FINANCIAL PLAN**

	A	B	C	D	E	F	G	H	I	J	K	L	M
1				2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
3	**A**		**Opening Financial Position**										
4			Clyde Deficit brought forward	(19.0)	(12.0)	(4.0)	-						
5			less Planned Recurring Cost Savings (Clyde)	7.0	8.0	4.0	-						
6			less Planned Non Recurring Items	4.0	-	-	-						
7			less Transitional SGHD funding (assumed)	8.0	4.0	-							
9	**Adjusted Opening Financial Position**			-	-	-	-	-	-	-	-	-	-
11	**B**		**New Funding**										
12	1		SEHD general funding uplift	54.0	55.7	57.4	59.2	61.0	62.9	[redacted]	[redacted]	[redacted]	[redacted]
13	2		Waiting Times	7.0	8.0	8.0	-	-	-	-	-	-	-
14	3		Other	13.7	13.9	14.0	14.2	14.3	14.4	[redacted]	[redacted]	[redacted]	[redacted]
16	**Total New Funding**			74.7	77.6	79.4	73.4	75.3	77.3	[redacted]	[redacted]	[redacted]	[redacted]
18	**C**		**Expenditure Commitments**										
19	1		Pay costs inflation	35.5	30.4	27.9	28.3	28.8	29.3	[redacted]	[redacted]	[redacted]	[redacted]
20	2		Prescribing costs growth	19.5	20.7	21.9	23.2	24.6	26.1	[redacted]	[redacted]	[redacted]	[redacted]
21	3		Other supplies costs inflation	5.6	5.7	5.8	8.8	8.9	9.0	[redacted]	[redacted]	[redacted]	[redacted]
22	4		Energy	3.5	-	-	-	-	-	-	-	-	-
23	5		Capital charges inflation	2.0	1.0	1.0	1.0	1.0	1.0	[redacted]	[redacted]	[redacted]	[redacted]
24	6		PMS & PCS	5.3	5.5	5.6	5.7	5.8	5.9	[redacted]	[redacted]	[redacted]	[redacted]
26	7		Other Providers	4.4	4.6	4.8	5.0	5.2	5.4	[redacted]	[redacted]	[redacted]	[redacted]
27	8		Existing Programme Commitments										
28		(i)	Brought Forward	7.0	5.0	5.0	3.0	3.0	3.0	[redacted]	[redacted]	[redacted]	[redacted]
29		(ii)	Acute Capacity Plan / Waiting Times	7.0	8.0	8.0	-	-	-	-	-	-	-
30		(iii)	Acute ASR Programme	0.3	21.0	2.0	-	-	13.0	[redacted]	-	-	-
31		(iv)	Other Acute	4.3	5.7	0.4	5.0	-	-	-	-	-	-
32		(v)	CHCP / CHP / MH / Other	2.9	2.6	1.0	1.0	-	-	-	-	-	-
33		(vi)	In-Year Commitments c/f	(5.0)	(5.0)	(3.0)	(3.0)	(3.0)	(3.0)	[redacted]	[redacted]	[redacted]	[redacted]
35				92.3	105.2	80.4	78.0	74.3	89.7	[redacted]	[redacted]	[redacted]	[redacted]
40	**9**		**Prospective Programme Commitments**										
42		(i)	Acute	-	4.0	4.0	4.0	4.0	4.0	[redacted]	[redacted]	[redacted]	[redacted]
43		(ii)	CHCP / CHP / MH / Other	-	4.0	4.0	4.0	4.0	4.0	[redacted]	[redacted]	[redacted]	[redacted]
45	**Total Prospective Programme Commitments**			-	8.0	8.0	8.0	8.0	8.0	[redacted]	[redacted]	[redacted]	[redacted]
48	**Total Expenditure Commitments**			92.3	113.2	88.4	86.0	82.3	97.7	[redacted]	[redacted]	[redacted]	[redacted]
54	**Cost Savings Plans (exc Clyde)**			(26.2)	(27.0)	(33.4)	(12.0)	(13.1)	(10.0)	[redacted]	[redacted]	[redacted]	[redacted]
57	**Projected In-Year Surplus / (Deficit)**			8.6	(8.6)	24.4	(0.6)	6.1	(10.4)	[redacted]	[redacted]	[redacted]	[redacted]
59	Recurring Surplus / (Deficit) brought forward				8.6	-	24.4	23.8	29.9	[redacted]	[redacted]	[redacted]	[redacted]
61	**Projected Recurring Surplus / (Defict)**			8.6	-	24.4	23.8	29.9	19.5	[redacted]	[redacted]	[redacted]	-
63	Provision for Transitional Costs Associated with Establishing new Adult / Children's Hospitals			(8.6)	-	(24.4)	(23.8)	(29.9)	(8.5)	[redacted]	[redacted]	-	-
65	**Projected Net Surplus / (Defict)**			-	-	-	-	-	11.0	[redacted]	-	[redacted]	-

SECTION 9.4.2

10 YEAR FINANCIAL PLAN

COST SAVINGS PLAN

	A	B	C	D	E	F	G	H	I	J	K	R	S
1		**2008/09 £m**	**2009/10 £m**	**2010/11 £m**	**2011/12 £m**	**2012/13 £m**	**2013/14 £m**	**2014/15 £m**	**2015/16 £m**	**2016/17 £m**	**2017/18 £m**	**Total £m**	
2													
3													
4	**ASR Cost Savings**												
5	Capital Charges		2.4			3.1	1.0	[redacted]	[redacted]	[redacted]		[redacted]	
6	Nursing			3.0	3.0			[redacted]				[redacted]	
7	Medical							[redacted]	[redacted]			[redacted]	
8	Other		0.5			1.0		[redacted]	[redacted]	[redacted]		[redacted]	
9													
10	**ASR Cost Savings**		2.9	3.0	3.0	4.1	1.0	[redacted]	[redacted]	[redacted]		[redacted]	
11													
12	**Other Cost Savings**												
13	Clyde Cost Savings	7.0	8.0	4.0									
14	Other Savings	26.2	24.1	30.4	9.0	9.0	9.0	[redacted]	[redacted]	[redacted]	[redacted]		
15													
16	**Other Cost Savings**	33.2	32.1	34.4	9.0	9.0	9.0	[redacted]	[redacted]	[redacted]	[redacted]		
17													
18													
19	**Total Savings**	33.2	35.0	37.4	12.0	13.1	10.0	[redacted]	[redacted]	[redacted]	[redacted]		
20													
21	less Clyde Savings separately disclosed	(7.0)	(8.0)	(4.0)									
22													
23	**Total Savings (exc Clyde)**	26.2	27.0	33.4	12.0	13.1	10.0	[redacted]	[redacted]	[redacted]	[redacted]		
24													
25													

NHSGG&C(M)08/3
Minutes: 34 - 53

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 15 April 2008 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Mr J Bannon MBE
Dr C Benton MBE
Mr R Cleland
Councillor J Coleman (to Minute 42)
Dr D Colville (to Minute 43)
Dr B Cowan
Ms R Crocket (to Minute 42)
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin (to Minute 42)
Mr P Hamilton
Councillor J Handibode
Dr M Kapasi MBE
Councillor J McIlwee
Councillor D MacKay
Mr G McLaughlin
Mrs R K Nijjar (to Minute 41)
Councillor I Robertson
Mr D Sime
Councillor A Stewart
Mrs A Stewart MBE
Mr B Williamson (to Minute 45)
Councillor D Yates

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning (to Minute No 41)
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources

ACTION BY

34. APOLOGIES

Apologies for absence were intimated on behalf of Professor D Barlow, Mr G Carson, Dr L de Caestecker, Mrs A Coultard, Mr P Daniels OBE, Mrs J Murray and Mrs E Smith.

35. CHAIR'S REPORT

(i) Mr Robertson reported that Mrs E Smith had intimated an interest in the role of NHS Board Vice Chair.

Other members who had shown an interest had withdrawn. The proposal that Mrs Smith be appointed Vice-Chair would arise under Item No 11 later in the agenda and Mr Robertson encouraged the NHS Board to support her appointment.

(ii) On 22 February 2008, Mr Robertson had met with both Chairs of the North and South Monitoring Groups set up under the Acute Services Strategy to monitor named services at Stobhill Hospital and the Victoria

ACTION BY

Infirmary. It had been re-assuring to hear from them that they continued to receive all relevant information and that a good sense of engagement had been established in both areas.

In this regard, Mr Robertson paid tribute to the NHS Board's Community Engagement Team for ensuring consistent information was conveyed to local communities.

(iii) On 29 February 2008, Mr Robertson visited staff at Tara House where a large section of Human Resources (HR) teams had now been relocated. This paved the way for ongoing integration between NHS Greater Glasgow and Clyde staff.

(iv) On 10 March 2008, Mr Robertson and Mrs E Smith had met with leaders of Inverclyde Council – a meeting that had been set up by Councillor McIlwee. This had proved a good meeting and Mr Robertson had been encouraged by their willingness to maintain a regular dialogue with the NHS Board. He thanked Councillor McIlwee for his support in this iniative.

(v) The official opening of the new Gartnavel Royal Hospital by the Cabinet Secretary for Health and Wellbeing had taken place on 7 April 2008. This was an impressive new facility which would provide high quality care for patients.

(vi) Mr Robertson had attended the unveiling of Hamish McDonald Beatson Drawings 2007/08 at the Woolfson Medical School. Mr McDonald had been a patient at the Beatson Oncology Centre and, as a gifted artist, had illustrated his journey of care and treatment. Mr Robertson had taken this opportunity to also meet with Professor Anna Dominiczak who provided a tour of the clinics and laboratories within the new Translational Centre which had been very interesting. In a similar vein, Mr Robertson had toured the Beatson Institute for Cancer Research facility the previous week when Professor Karen Vousden had shown him the work at that Centre. From both tours he had gained tremendous encouragement of the world class research being undertaken.

(vii) In recognition of the Territorial Army (TA) celebrating its centenary, Mr Robertson encouraged the NHS Board to identify any employees within the NHS who were TA volunteers in order to celebrate their contribution.

(viii) Mr Robertson referred to two new initiatives for staff, namely, "Ideas in Action Award", designed to recognise and encourage good ideas across the organisation and the "NHS Diamond Awards", which were part of plans to celebrate the 60th anniversary of the NHS. Nominations were welcomed for both awards and he encouraged NHS Board Members to support the new initiatives and encourage staff to apply.

(ix) Mr Robertson referred to a series of master classes that the NHS Board was conducting for senior management. The first of these was on leadership and Mr Robertson invited NHS Board Members to attend.

NOTED

36. CHIEF EXECUTIVE'S UPDATE

(i) On 28 February 2008, Mr Divers had been delighted to participate in a summit meeting, led by Councillor D MacKay, with Renfrewshire Council on alcohol.

(ii) On 6 March 2008, Mr Divers was asked to give a key note address at the **Chief Executive**

ACTION BY

Keep Well Conference on anticipatory care. The first phase of this initiative was being rolled out in North and East Glasgow with the second phase scheduled for South Glasgow, West Dunbartonshire and Inverclyde. So far, early lessons had been learned from phase one and these would be presented to the NHS Board at a future seminar.

(iii) On 26 March, Mr Divers had attended the Annual Child Protection Conference in Renfrewshire Council. There had been very compelling key note addresses made at this conference and work was ongoing with each Local Authority to progress this work including an emphasis on identifying risk.

(iv) On 27 March 2008, Mr Divers had joined Councillor Yates to acknowledge and receive the Her Majesty's Inspectorate of Education (HMIE) Report on child protection for East Renfrewshire Council. This had been a positive report with many areas of good work being recognised. He thanked all staff involved in the inspection and noted that an action plan had already been developed to address the cases identified for further input.

NOTED

37. MINUTES

On the motion of Dr C Benton, seconded by Dr M Kapasi, the Minutes of the meeting of the NHS Board held on Tuesday, 19 February 2008 [NHSGG&C(M)08/2] were approved as an accurate record and signed by the Chair.

NOTED

38. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted.

(ii) In respect of Item 23 "New South-side Hospital, New Children's Hospital and New Laboratory Build – Approval of the Outline Business Case", Ms Byrne was hopeful that, by the end of April 2008, an announcement would be made by the Scottish Government on the Outline Business Case submitted for their consideration. In the meantime, Ms Byrne described work that was ongoing to progress the development as follows:

- Procurement options for the new hospitals were being explored.
- Governance arrangements had been approved at the March ASR Programme Board meeting and would be submitted to PRG in May 2008.
- Visits had taken place to two English hospitals to establish lessons learned and areas of best practice.
- Bed modelling work was ongoing.

Mr Robertson was reassured that ongoing work in these key four areas prepared the NHS Board for the next stage in the process.

(iii) In respect of Item 27 "Clyde Services Update", Mr Divers reported the following:

ACTION BY

- The consultations on services provided at Johnstone Hospital, Clyde inpatient disability services, Clyde maternity services review and modernising Clyde mental health services had all been launched. The consultation on changes to unscheduled medical care at the Vale of Leven Hospital was still being drafted with Scottish Government Health Directorate colleagues' participation.

  Part of this work involved exploring further one of the options from the Independent Scrutiny Panel Report on retaining the status quo for a specified period with the continuation of anaesthetic support to permit evaluation of the prediction model. The Cabinet Secretary had made it clear that she wanted, if it was possible, to include within the consultation pack any piece of audit work that could inform that option further.

NOTED

39. NHS GREATER GLASGOW AND CLYDE UPDATE ON CHILD PROTECTION UNIT

A report of the Board Nurse Director [Board Paper No 08/16] asked the NHS Board to note progress made by NHSGGC's Child Protection Forum from June 2007 and agree to receive a further update in October 2008.

Ms Crocket described the context of the Child Protection Unit and how the work of the Child Protection Forum continued to be rooted in the key objectives of national policies and the Government's vision for children to be safe, nurtured, healthy, achieving, active, respected and responsible and included.

Ms Crocket explained that because the Child Protection Unit was not a front-line operational service but set up to strengthen organisational arrangements in respect of child protection, it was not easy to evidence directly outcomes for children. It was, however, agreed that the area that could most likely be evidenced was in the recently introduced early sharing and collation of information systems where there could be some tracking of decision making where information was shared early with other agencies. As such, an evaluation of this service would be done once it had been up and running for one year.

Over and above this, there had been two main areas of activity that had central focus in the Child Protection Unit in recent months:

- HMIE child protection multi agency inspections – Ms Crocket described the three year programme of inspections introduced in 2005. In terms of the NHS Board's area, Renfrewshire was scheduled for May 2008, Inverclyde for June/August 2008 and Glasgow City in November 2008. Key messages for NHSGGC could be extracted from the four relevant published inspection reports to date from East Dunbartonshire (pilot and follow through), West Dunbartonshire and East Renfrewshire.

- Paediatric/forensic medical redesign – work was in its early stages to redesign all roles, responsibilities and accountabilities in paediatric and forensic medical services. Work was also currently underway to improve tripartite discussion/initial referral discussion arrangements across agencies as well as developing more appropriate child protection services for adolescents.

ACTION BY

Mr Williamson referred to the HMIE reports already published and, in particular, areas highlighted as requiring improvement. Within this list, although some could be achieved in the short/medium term, many were longer term aspirations. Mr Williamson wondered about the action plan and timescales for these. Ms Crocket explained that following an HMIE inspection, local action plans were developed to meet any shortfalls. Thereafter, monitoring was via local Child Protection Committees and the NHS Board's Child Protection Forum. She accepted that some would take time to implement but commended the high awareness of child protection issues within the NHS Board's responsibilities – both at CH(C)P level and within the Acute Division.

Councillor MacKay commended this as an excellent example of partnership working and the positive outcomes of professionals working together to build expertise and good practice.

In response to a question from Mrs Stewart, Ms Crocket confirmed that partners included Social Work Services, Education Services, housing providers, Police Service and voluntary organisations. Mr Divers referred also to the Chief Officers Group and its role to ensure action plans were driven forward and the platform it provided to look at cross-cutting issues across each agency. He suggested that, with the next update report, Ms Crocket include some progress of developments with some examples from Local Authorities working with NHSGGC. **Nurse Director**

Councillor Handibode recognised the achievements made by the Child Protection Unit in three years. He was concerned to note, however, that GPs rarely attended child protection meetings or submitted reports in some areas. Ms Crocket responded by confirming that an audit had been undertaken to establish who from practices attended case conferences and, as a result of this, a policy had been developed to prepare staff to attend case conferences. The case conference policy and guidelines did suggest that a practice could be represented by the most appropriate person be that the GP or the health visitor. Dr Colville re-iterated that often the health visitor was best placed to attend case conferences on behalf of GPs as they were the frontline provider for this work and it would be important to preserve that contact. Dr Kapasi recognised that often GPs found it difficult to attend case conferences in terms of getting locum cover and the nature of child protection case conferences meant they were often at short notice. In respect of the changing role of health visitors, Ms Crocket explained that the NHS Board had been in dialogue with educational establishments to ensure that undergraduate programmes accommodated this aspect of their role.

Mrs Nijjar asked about staff training and Ms Crocket explained that there was a comprehensive programme at CH(C)P level as well as inter-agency training ranging from basic awareness to targeted specific areas such as A & E Departments and Maternity Units. GPs could also access online training and CD-roms could be used locally in ward environments. Dr Kapasi explained that GPs and primary care staff had protected learning time and this could be used for child protection training to share experiences together as a primary care team. Dr Colville agreed with this suggestion and described how training could also be undertaken in the wider CH(C)P environment. Ms Crocket confirmed that all CH(C)P Directors had a training plan for this purpose.

DECIDED:

- That the progress made by NHS Greater Glasgow and Clyde Child Protection Forum from June 2007 be noted.

- That a further update report be considered by the NHS Board in October 2008. **Nurse Director**

ACTION BY

40. NATIONAL DELIVERY PLAN FOR CHILDREN AND YOUNG PEOPLE'S SPECIALIST SERVICES IN SCOTLAND – CONSULTATION DOCUMENT : NHS GREATER GLASGOW AND CLYDE CONSULTATION PROCESS

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/17] asked the NHS Board to note the publication of the National Delivery Plan (NDP) for specialist children's services in Scotland which was the subject of consultation until 28 May 2008 and provide comments for incorporation into the consultation feedback.

Ms Byrne described the background to the formation of the NDP which saw a National Steering Group for specialist children's services in Scotland being established in 2006. Both Ms Byrne and Dr Iain Wallace, Associate Medical Director for Women and Children's Services, were members of this group representing NHSGGC.

Detailed work was undertaken on a range of areas which included specific service reviews, planning and commissioning, networks, age appropriate care, models of care and review of workforce requirements. The major areas of focus for the National Steering Group were on priority areas for action including:

- Children's cancer services
- Inherited metabolic diseases and cystic fibrosis
- Paediatric rheumatology
- General surgery of childhood

The Group sought to avoid duplicating work already completed or underway while also seeking to ensure that, wherever relevant, the National Delivery Plan complemented other national work streams. It was recognised that the NDP, even taken in conjunction with the other work streams, did not address the full spectrum of specialist children's services.

The Scottish Government issued the draft NDP in February 2008 for formal consultation until 28 May 2008 and at the same time announced an extra £32m investment over the next three years to support implementation of the NDP. Ms Byrne explained that this represented £2m in year one, £10m in year two and £20m in year three although it had not yet been determined how this funding would be allocated nor whether it would be made recurrent. The Cabinet Secretary for Health made a commitment in the document to the development of two new children's hospitals, one in Glasgow and one in Edinburgh complementing what had already been achieved in Aberdeen and Dundee.

Ms Byrne highlighted some of the reasons why change was proposed and why, within Scotland, there had been difficulties in sustaining the current pattern of delivery of specialist children's services.

Ms Byrne acknowledged that whilst progress had been made in developing specialist children's services nationally and the funding allocation was very much welcomed, throughout the development of the NDP, there had been considerable clinical concern about the sustainability of specialist children's services, in particular, cancer services and paediatric neurosciences in a country with the population size of Scotland.

ACTION BY

In terms of supporting participation in the formal consultation process, Ms Byrne outlined the structured process for responses within the Acute Division and the co-ordination of those responses with those that were submitted from CH(C)P organisations. Furthermore, a copy of the consultation response, prior to submission to the Scottish Government Health Department, would be shared with Local Authority partners.

Mr Williamson was concerned to note that NICE guidelines had been ignored and questioned the sustainability of four sites across Scotland for children's cancer. He referred, in particular, to staff development and training within these centres if outcomes were diluted to a degree by such a small number of children's cancers being treated.

Mr Cleland highlighted the sensitive area in moving from children's services to adult services and the often difficult transition this involved for children. As such, he welcomed the inclusion of age appropriate care.

Mr Divers explained that a lot of work had been undertaken regarding specialist cancer services in children recently and this consultation provided an opportunity to get a wide range of views on how this could be best developed. He was hopeful that the funding would be recurring and that, in terms of prioritisation of this, it would be paramount to get the best return from the investment.

Mr McLaughlin enquired about the timing and sequencing of the NDP given the progress already made for the new children's hospital on the NHS Board's south-side campus. Ms Byrne confirmed that there were unlikely to be any major changes arising from the NDP that would have an impact on the plans for the new Children's Hospital but confirmed that there was flexibility drawn into their plans if changes were required.

DECIDED:

- That the publication of the National Delivery Plan (NDP) for specialist children's services in Scotland which was subject to consultation until 28 May 2008 be noted.

- That comments from the NHS Board be incorporated into the consultation feedback. **Director of Acute Services Strategy, Implementation and Planning**

41. REVIEW OF NHS CONTINUING CARE FOR FRAIL ELDERLY

A report of the Chief Executive and Director of Rehabilitation and Assessment [Board Paper No 08/18] asked the NHS Board to note the outcome of the review of planning for NHS Continuing Care for frail older people resident in NHS Glasgow and agree that the implementation of the shift in balance of care be continued.

Mr Divers described the background to the review of NHS Continuing Care in the NHS Board's former area, NHSGG. He presented the review of previous planning assumptions and updated on the implementation of further service change explaining that this was concluding a change programme in NHS continuing care of eleven years.

ACTION BY

Mr Divers led the NHS Board through the 2005 agreed plan between NHS Greater Glasgow and Glasgow City Council (GCC) on "Review of Provision and Plans for Institutional Care for Older People in the City of Glasgow". Within this, was a section on NHS Continuing Care which had been approved by the Joint Community Care Committee with the recommendation that a further review be undertaken in 2008. In that plan, it was recommended that there be a reduction in NHS Continuing Care beds from December 2004 (656 beds) to a planned figure of 312 beds, with the objective of achieving that shift in the balance of care by 2007. Mr Divers outlined that this reduction was based on a number of factors, including:

- A declining number of admissions to continuing care as a wider range of community services became available.

- A declining length of stay in the beds as patients were generally admitted in the last months of their lives.

- A reduction in the number of patients awaiting discharge who were inappropriately in continuing care beds.

Mr Divers explained that the number of beds had been reducing since the late 1990s and illustrated a reduction of 240 beds since the plan was agreed on 2002. The final phase of reduction had not yet been implemented but included the closure of 60 beds in the south of the city and 26 beds at St Margaret's in the west of the city. This would lead to the provision of NHS Continuing Care on three sites in the north of the city and three in the south of the city. The majority of beds would be provided in units of 60 to provide critical mass for clinical staff and, in particular, to facilitate cover by medical staff.

In terms of reviewing planning assumptions, the updated "balance of care" study had included a review of each of the key elements of the planning assumptions which were relevant to that exercise. In turn they comprised:

- A review of admissions – in order to identify the number of true continuing care admissions, the number of discharges was subtracted from the number of total admissions. The discharges would have been of patients temporarily occupying the beds whilst awaiting a place in another type of care as part of their planned discharge.

- The pattern in average length of stay – the overall length of stay had continued to fall with the average length of stay of patients who had died falling in a similar way. The mean length of stay was higher than the median due to the continuing presence of patients who were admitted before the current criteria for use of continuing care were agreed. Notwithstanding this, the average length of stay had fallen substantially over the past six years. In December 2007, all continuing care providers were asked to complete a snapshot audit of current patients and their date of admission. At the point of that snapshot, only 270 of the available 416 beds were being used for continuing care patients. A similar snapshot was undertaken on 25 September and showed 282 beds in use. This equated to an average occupancy of 65 to 68% by patients meeting the criteria for NHS Continuing Care. The NHS Board would expect an average occupancy of 95%.

- The impact on future service requirements of the changing demographics among the elderly population over the next ten years – the average age of admission to NHS Continuing Care continued to be 82. From 2008 to 2018, a 25% increase in the number of people over the age of 80 could be expected. The increase in admissions which would flow from this change in demography could be met within the complement of 312 continuing care beds (which allowed for a 15% increase in admissions over the next decade).

ACTION BY

Mr Divers confirmed that further discussions would take place with St Margaret's to agree a detailed implementation plan to cease the continuing care service and to continue to encourage them to shift the type of care provided there to a social care model in partnership with Local Authority colleagues or another model consistent with shared NHS/GCC requirements. It was not intended that current continuing care patients at St Margaret's would be moved to another ward and this would form part of the implementation discussions. There was a clear demand for that type of service in that area.

Mr Robertson reported that Des McNulty MSP had written to him in connection with the NHS Board's proposals. This was circulated to NHS Board Members and Mr Robertson hoped to meet with Mr McNulty to discuss the issues he had raised, ahead of the meeting with St Margaret's on 2 May 2008.

Councillor Coleman advised that Glasgow City Council was supportive of the continued implementation of the shift in the balance of care.

Councillor Robertson sought clarification around the resources required for the transfer from a continuing care service to a social care model. Mr Divers described the migration process between the NHS Board and Local Authorities and other providers during the implementation of this plan. To date, for the other providers, the resource implications of the new model of care and transitional funding had been agreed with the final contracts being signed off. Mr Divers had confidence in this model and, in particular, in its longevity.

Councillor Stewart considered the implications of the recommendations and, at this stage, was not comfortable with them being agreed on that day. She referred to the public concern about the removal of the continuing care beds from St Margaret's and to a 90,000 signature petition presented to the Scottish Government. She suggested that before any decision was made in relation to the shift of care to a social care model, this model be further explored and a full report presented to the NHS Board on its findings which should include the input from the Local Authority to ensure that their views concurred with that of the NHS Board's. She asked that the NHS Board defer its decision until it received a fuller report following discussions with St Margaret's Hospice due to take place on 2 May 2008.

Mrs Stewart sought a breakdown of residents in a north/south split. Mr Calderwood confirmed that this projection would be possible. Furthermore, she wondered about provision in the new hospital at the Victoria and the likelihood of NHS provision to elderly patients there. Mr Calderwood reported that it would have available 48 elderly slow stream patient beds.

Chief Operating Officer

Mr Williamson was content to accept the recommendations as they stood and welcomed the flexibility of returning to the projections if they required modification. He considered that a good projection measure would be to evaluate re-admission rates as this would give an indication to where community services were not being provided and patients were required to be re-admitted to continuing care beds. Mr Divers reported that there were no re-admissions within NHS Continuing Care. Mr Williamson reported that with this care group, it was important to periodically look at whether the strategy remained fit for purpose and/or whether increased dependency required increased capacity. Mr Divers assured the NHS Board that this would take place especially as any planning assumptions had an element of risk associated with them.

Mr Bannon was under the impression that Glasgow City Council was about to conduct a review of its residential care beds – he wondered what implications this may have. Mr Divers was unaware of such a review.

ACTION BY

Councillor Yates referred to the continuing care beds in Mearnskirk House and appealed to the NHS Board to review transport links to this site as they were currently poor. Mr Divers confirmed that he would be happy to pick this up with the Community Engagement Team. **Chief Executive**

In response to a question from Ms Dhir, Mr Divers explained that the review was being conducted for the old boundary of NHS Greater Glasgow only at the moment as this was what fell under the 2005 agreement between the previous NHS Board and Glasgow City Council.

He confirmed that the numbers from the previous NHSGG population remained as a basis for a reasonable planning process. In relation to the majority of beds being provided in units of 60, this provided critical mass for clinical staff and, in particular, facilitated cover by medical staff. He accepted that Mearnskirk House had a quota of 72 beds but this had formed part of their original contract and it did not make sense to change that at this stage. The total of 312 continuing care beds for Glasgow was considered a reasonable planning assumption. Ms Dhir thought that Clyde should be included in the NHS Board's review so that the totality of the NHS Board's area could be looked at.

Mr McLaughlin intimated that the historical perspective and analysis, together with the sequencing of events, had been very helpful and he was re-assured by that detail provided by Mr Divers. He understood that other providers had been involved in NHS Continuing Care, however, he did reflect that St Margaret's was, in essence, a slightly different type of provider which had its basis as a charity. He was sure that the meeting set for 2 May 2008, between the NHS Board Chair and the Chief Executive and the representatives of St Margaret's Hospice, would deal with the adjacencies and interdependency issues. He wondered what other options could be put to St Margaret's Hospice to ensure their sustainability.

Mr Divers replied that there had never been a proposition simply to remove the 30 NHS Continuing Care beds from St Margaret's. There were two propositions; one was that the beds be redesignated as elderly continuing care with mental illness and the second that the beds be re-designated as Enhanced Social Care Beds. He (and the former NHS Board Chair) had had three meetings with representatives from St Margaret's over the last three years and clear options had been put to St Margaret's in an attempt to ensure the sustainability of the Hospice. St Margaret's preference was to stay in partnership with the NHS Board and, therefore, had a preference for continuing care beds remaining at St Margaret's rather than enhanced social care beds. Real efforts had been made to try and find a way forward that would not involve any financial risk for St Margaret's; on reflection, Mr Divers did wonder whether this dialogue should have been pushed more at an earlier date. He was keen that he and the Chair should meet with St Margaret's on 2 May 2008 and would do so with a commitment to try and find an acceptable way forward which dealt with the adjacencies and interdependencies.

Dr Benton asked why there was not a proportionate increase in admissions if there was a projected 25% increase in the population over 80 years of age. Mr Divers advised that the continued development of community services would result in a likely 15% increase in admissions and this had been built into the planned number of beds (312).

ACTION BY

With this in mind and given that it was difficult to pre-empt the outcome of the discussion on 2 May, Councillor Stewart suggested that the NHS Board consider a further report from the Chair and Chief Executive following their meeting with St Margaret's. Councillor MacKay, Mrs Stewart and Mr Bannon agreed with this particularly as there was no need to rush this decision. Councillor Robertson was of the view that given the huge public concern, the NHS Board had an obligation to listen regardless of the support from other agencies to the proposals. Councillors Coleman and Handibode, Mr Sime and Mr Hamilton advised that they remained happy to support the NHS Board's recommendation to continue with the implementation of the shift of the balance of care.

Mr Robertson recognised the difficult decision that was required particularly around such a sensitive issue. Nonetheless, given the full debate and views of NHS Board Members, he agreed to recommend the decision be deferred until following the 2 May 2008 meeting. That, in turn, would mean that the matter would be further considered by the NHS Board at its June 2008 meeting.

Mr Divers recognised the sensitivity of the issue and was pleased that Members were comfortable with the analysis provided in the NHS Board paper. In continuing the discussion to the next NHS Board meeting in June 2008 in order to reflect the discussions with St Margaret's, he expressed the hope that St Margaret's would come to the 2 May 2008 meeting prepared to discuss constructively how these issues could be moved forward.

DECIDED:

- That the outcome of the review of planning for NHS Continuing Care for frail older people resident in NHS Greater Glasgow be noted.

- That the decision to be made on the continued implementation of the shift in the balance of care be deferred until the June 2008 NHS Board meeting in order to reflect the discussions with St Margaret's at the meeting to be held on 2 May 2008. **Chairman/Chief Executive**

42. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 – LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 08/19] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the four Medical Practitioners listed on the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

43. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No 08/20] asked the NHS Board to note progress against the national targets as at the end of February 2008.

ACTION BY

Mr Calderwood led the NHS Board through progress across the single system towards achieving waiting time and other access targets set by the Scottish Government Health Directorate – commonly known at HEAT Targets. He explained that this would be the final report to be presented focusing on these targets. A new format would be developed for the June 2008 NHS Board focusing on the revised HEAT targets which had been agreed with the Scottish Government towards the 2011 target of 18 weeks from referral to treatment.

In response to a question from Mr Sime, Mr Calderwood confirmed that the building vacated by the Beatson Oncology Centre (on the Western Infirmary site) was being utilised for medical receiving to deal with pressure from the Accident and Emergency Department.

Councillor MacKay welcomed the NHS Board's performance in relation to delayed discharges and Mr Calderwood confirmed that the census information regarding delayed discharges was scheduled to be published at the end of April.

NOTED

44. NHS GREATER GLASGOW AND CLYDE – ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No 08/21] asked the NHS Board to approve, note and agree the new governance arrangements being put into place.

Mr Hamilton reminded the NHS Board that, in February 2005, it approved the new organisational arrangements to implement the White Paper "Partnership for Care". Subsequently, two significant reviews of the governance arrangements took place as the moves to single system working were carried out and, as a result, the NHS Board approved in December 2006 a detailed set of new governance arrangements to support the new organisation.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board properly to discharge is responsibilities and statutory functions. The Audit Committee had considered the annual review of the corporate governance documentation at its meeting on 25 March 2008 and had endorsed the submission to the NHS Board and recommended its approval.

DECIDED:

(i) That the revised Standing Orders for the proceedings and business of the NHS Board and the decisions reserved for the NHS Board (Board Paper Appendix 1) be approved. **Head of Board Administration**

(ii) That the changes to the Standing Financial Instructions be approved. **Director of Finance**

(iii) That the remits of the Standing Committees – Audit (Board Paper Appendix 2), Clinical Governance (Board Paper Appendix 3), Staff Governance (Board Paper Appendix 4), Performance Review Group (Board Paper Appendix 5), Involving People (Board Paper Appendix 6), Research Ethics Governance (Board Paper Appendix 7), Pharmacy Practices (Board Paper Appendix 8) and Area Clinical Forum (Board Paper Appendix 9) be approved. **Head of Board Administration**

(iv) That delegation to the CH(C)P Committees and Mental Health Partnership Committee of the authority to approve future amendments to their own Standing Orders be agreed. **Head of Board Administration**

ACTION BY

(v) That the memberships of the Standing and CH(C)P Committees (Board Paper Appendix 10) and delegation to the CH(C)P and Mental Health Partnership Committee of the authority to approve future changes to their membership and submit annually for NHS Board approval be agreed and approved. **Head of Board Administration**

(vi) That the membership of the Adults with Incapacity Supervisory Body (Board Paper Appendix 11) be approved. **Head of Board Administration**

(vii) That the list of authorised officers to sign Healthcare Agreements and related contracts (Board Paper Appendix 12) be approved. **Head of Board Administration**

(viii) That the appointment of Ms Elinor Smith as Vice Chair of the NHS Board for a period of four years, or to the end of her term of office, whichever was earlier be endorsed. **Head of Board Administration**

45. QUARTERLY REPORT ON COMPLAINTS : 1 OCTOBER 2007 – 31 DECEMBER 2007

A report of the Head of Board Administration, Chief Operating Officer (Acute) and Lead Director, CHCP (Glasgow) [Board Paper No 08/22] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 October to 31 December 2007.

Mr Hamilton led the NHS Board through the commentary and statistics on complaints handling referring, in particular, to areas of service improvements and ongoing developments. Throughout the period, 361 complaints have been received with 183 (51%) being received and completed within the national target of 20 working days.

Mr Hamilton referred to this disappointing performance and reported that the Acute Services Division had recently undertaken a full review of how it handled complaints and identified a number of operational issues in which they believed would be able to improve future performance.

NOTED

46. FINANCIAL MONITORING REPORT TO 31 JANUARY 2008

A report of the Director of Finance [Board Paper No 08/23] asked the NHS Board to note the financial monitoring report for the ten month period to 31 January 2008.

Mr Divers highlighted that, as at 31 January 2008, NHSGGC was reporting expenditure levels running £4.1m below the year to date budget of £2096.5m. This confirmed that the NHS Board continued to manage its expenditure levels in line with budget. As such, the NHS Board continued to forecast a revenue break-even position for 2007/08. The ability to achieve this, however, would depend on the timing of expenditure against further ring-fenced funding allocations received in the final two months of the year, the impact of which could potentially produce a year-end surplus of up to £5m.

NOTED

ACTION BY

47. PHARMACY PRACTICES COMMITTEE MEETING MINUTES : 8 FEBRUARY 2008, 22 FEBRUARY 2008, 26 FEBRUARY 2008, 6 MARCH 2008, 10 MARCH 2008 AND 14 MARCH 2008

The Minutes of the Pharmacy Practices Committee meetings held on 8 February 2008, 22 February 2008, 26 February 2008, 6 March 2008, 10 March 2008 and 14 March 2008 [PPC(M)08/02 to PPC(M)08/07]were noted.

NOTED

48. CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES : 5 FEBRUARY 2008

The Minutes of the Clinical Governance Committee meeting held on 5 February 2008 [CGC(M)08/1] were noted.

NOTED

49. AREA CLINICAL FORUM MEETING MINUTES : 7 FEBRUARY 2008

The Minutes of the Area Clinical Forum meeting held on 7 February 2008 [ACF(M)08/1] were noted

NOTED

50. AUDIT COMMITTEE MEETING MINUTES : 30 JANUARY 2008 AND 25 MARCH 2008

The Minutes of the Audit Committee meetings held on 30 January 2008 [A(M)08/01] and 25 March 2008 [A(M)08/02] were noted.

NOTED

51. STAFF GOVERNANCE COMMITTEE MEETING MINUTES : 19 FEBRUARY 2008

The Minutes of the Staff Governance Committee meeting held on 19 February 2008 [SGC(M)08/1] were noted.

NOTED

52. PERFORMANCE REVIEW GROUP MEETING MINUTES : 18 MARCH 2008

The Minutes of the Performance Review Group meeting held on 18 March 2008 [PRG(M)08/02] were noted.

53. MENTAL HEALTH PARTNERSHIP COMMITTEE MEETING MINUTES : 28 FEBRUARY 2008

The Minutes of the Mental Health Partnership Committee meeting held on 28 February 2008 [2007/02] were noted

The meeting ended at 12.45 pm

NHSGG&C(M)08/7
Minutes: 96 - 115

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 21 October 2008 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE
Professor D Barlow
Mr G Carson
Mr R Cleland
Councillor J Coleman (to Minute 105)
Dr D Colville (to Minute 106)
Dr B Cowan
Mr P Daniels OBE
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Councillor J Handibode (to Minute 110)
Dr M Kapasi MBE
Mr I Lee
Councillor D MacKay
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar (to Minute 110)
Councillor I Robertson
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE
Councillor A Stewart
Mr B Williamson

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning (to Minute 110)
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mr A Lawrie	..	Director, South Lanarkshire CHP (to Minute 106)
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (to Minute 101)

ACTION BY

96. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon, Mrs A Coulthard, Ms R Crocket, Dr L de Caestecker and Councillor D Yates.

97. CHAIR'S REPORT

(i) Mr Robertson advised that he had visited the Accident and Emergency Department, Victoria Infirmary to talk to staff about the impending changes. On the same day he had attended Glasgow Royal Infirmary to present an 'Ideas in Action' Award to Susan Evans for her idea of recycling any clean paper/card/plastic thrown away as a result of normal daily activity at work.

He was joined by Mr Robert Calderwood, Chief Operating Officer – Acute Services Division on a visit to Inverclyde Hospital and was shown the new imaging equipment and heard about the renewed confidence from staff in promoting the Community Midwife Units to expectant mothers following the NHS Board's decision to retain the Units.

(ii) On 30 September he had attended the carers conference – 'How Good Are Our Services for Young Carers?' and heard from young carers looking after parents and other family members.

On 7 October he had Chaired the high level Policy discussion on Carers with representatives from the NHS, Social work, COSLA, Scottish Government and the Voluntary Sector. The meeting had been attended by the Princess Royal and had attracted good media coverage. There was now a better profile being achieved for carer issues and this was greatly welcomed and would be developed even further in the future.

(iii) On 15 September he had attended the regular meeting of the NHS Board and Glasgow University Strategy Group. There was a developing programme of joint work around research, education and future developments and much of this work would be intensifying in the coming months.

(iv) On 20 October, he was joined by Mr Tom Divers and Mr John Hamilton in meeting the two Chairs of the Monitoring Groups set up to monitor the retention of named services at Stobhill Hospital and the Victoria Infirmary. The Chairs were due to meet the Cabinet Secretary for Health and Well-being in mid-November to discuss the work of the Groups.

(v) Mr Robertson congratulated Mr Peter Hamilton and the Public Involvement Team for organising yet another highly successful Our Health Event. The topic was – Mental Health – and it attracted a large turn-out and a significant amount of positive feedback.

Lastly, the Chair advised that the NHS Board had been asked to note receipt of 5,536 slips signed by patients stating:

> "I am a patient on the [named] practice and I am writing to express my objections to your plans to remove health visitors from my GP practice.
>
> I am supporting my GP's call for an immediate halt to the current implementation of the review of Community Nursing and ask that the NHS Board undertake a new consultation that takes into account the views of the doctors, nurses and patients that will be affected by these changes."

Ms Renfrew advised that discussions were continuing with the Local Medical Committee and Trade Unions and Dr de Caestecker had submitted a proposal to the Local Medical Committee for discussion. Dr Colville advised that the Local Medical Committee had discussed the proposal at length the night before and would be meeting again shortly to conclude their deliberations. In response to comments made by Dr Kapasi, Ms Renfrew advised that the review of health visitors would see a mix of attachments to GP practices and in geographic teams and for both models the immunisations rates had been similar.

NOTED

98. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers advised that he would be meeting with Sir John Savill, the new Chief Scientist for NHS Scotland, and would be accompanied by Mr Robert Calderwood, Mr Douglas Griffin, Dr Brian Cowan, Professor David Barlow, Professor John Coggins and Professor Chris Packard to discuss the priorities for research in Scotland and how finance could be directed to the four Clinical Academic Centres – this could have financial planning implications for the NHS Board in a couple of years.

ACTION BY

(ii) Mr Divers referred to the pre-consultation period on the vision for the Vale of Leven Hospital. Meetings had been held to present the proposals for the Vale of Leven with Argyll and Bute Council in Lochgilphead, Hospital Watch and the Helensburgh and Lomond Locality Planning Group. A meeting was being arranged with West Dunbartonshire Council. The consultation documentation would be finalised to a sufficient level of detail to allow the launch of the formal consultation by the end of next week.

(iii) Lastly, Mr Divers advised that Mr Calderwood was reviewing whether a nurse-led chemotherapy service could be provided from the new Stobhill Ambulatory Care Hospital when it opened in the summer of 2009. Mr Divers advised that such a model would not be replicating the specialist oncology/chemotherapy service in the new Victoria Hospital. A previous decision when creating the new Beatson Oncology Centre had seen specialist oncology/chemotherapy services for the north and east of the city being located in the new West of Scotland Beatson Oncology Centre.

NOTED

99. MINUTES

On the motion of Mrs E Smith, seconded by Mrs A Stewart, the Minutes of the meeting of the NHS Board held on Tuesday, 19 August 2008 [NHSGG&C(M)08/5] were approved as an accurate record and signed by the Chair.

On the motion of Mrs E Smith, seconded by Mrs J Murray, the Minutes of the meeting of the NHS Board held on Tuesday, 16 September 2008 [NHSGG&C(M)08/6] were approved as an accurate record and signed by the Chair subject to the following amendment:

Minute 93 – Apologies and Welcome - delete second paragraph.

NOTED

100. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted.

(ii) In relation to Minute 79(i) – Chief Executive's Update – Mr Divers advised that the review of the audit of rooms in hospitals to ensure patient privacy and dignity by Acute Services and Mental Health would be completed by the end of the month and members would be advised in writing during November of the outcome. **Chief Executive**

NOTED

(iii) In relation to Minute 41- Review of NHS Continuing Care for Frail Elderly – in response to Cllr. Robertson's request for an update, Mr Divers advised that Ms A Harkness, Director – Rehabilitation and Assessment Directorate, had met with representatives of St Margaret's Hospice to discuss financial costings of modelling and consideration of local and national emerging work on non-cancer palliative care services.

ACTION BY

The outstanding piece of work related to the need to meet St Margaret's Hospice on the two alternatives – nursing home care or services for the elderly mentally ill. The intention was to conclude that debate in order that a paper could be submitted to the NHS Board meeting in December 2008. **Chief Executive**

NOTED

(iii) In relation to Minute 94 – Future Services at Vale of Leven Hospital – Pre-Consultation Document – in response to a question from Mr P Hamilton about the emerging issues during the engagement period, Mr Divers advised that the feedback to date had been positive.

In relation to the supported GP Acute Unit the two main issues were the volume of acute care and the staffing model. In addition, the other main area of discussion was whether there could be a viable local adult acute mental health in-patient service.

Ms Byrne advised that the Scottish Health Council feedback reports had been received for In-patient Disability Services, Older People's Services and Mental Health Services and they had been positive. In addition, the Cabinet Secretary had approved the NHS Board's proposals for In-patient Physical Disability Services in Clyde.

Dr Kapasi enquired about the work under way to progress the GP Acute Unit – he was advised that weekly meetings were being held with GPs and physicians from the Vale of Leven, Royal Alexandra Hospital and hospitals in Glasgow. Dr Benton was advised that unscheduled transport would be included in the consultation document. Once the consultation documentation had been finalised a copy would be sent to Members and it would be discussed at the NHS Board Seminar in November 2008. **Director of Acute Services Strategy Implementation and Planning**

NOTED

101. JOINT WORKING WITH GLASGOW CITY COUNCIL

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No. 08/46] asked the NHS Board to note the revised temporary arrangements for the management of the Glasgow CHCPs, to comment on the issues described in the paper and to consider how Non-Executives could be engaged in the CHCP development and joint working review processes.

Ms Renfrew took Members through the paper and highlighted that Glasgow City Council was the NHS Board's largest Local Authority partner and the one with which the Board faced the most significant challenge to deliver the intention to improve the health of the population served by the Board and to do everything possible to address inequalities.

In the last two years there had been substantial changes to the working arrangements with the City Council: Community Planning structures had been re-shaped, the City Council had merged its Education and Social Work Directorates and changed its management structures. These changes offered the potential of better joint working: however, they also presented challenges and there had been particular issues in the development of CHCPs within Glasgow. In establishing the arrangements outlined in the paper, the NHS Board was responding positively to the challenges by providing a stronger and more positive focus on the key organisational issues, with four main objectives:

(i) the development of the CHCPs which was consistent with the organisational model as agreed in the approved Scheme of Establishment;

(ii) beyond that, to develop with the City Council the next phase of the development of CHCPs in Glasgow to give fresh momentum to the wider reform agenda;

(iii) to agree and implement revised CHCP governance arrangements which give confidence that the NHS Board as an employer could meet its responsibilities to staff in joint posts;

(iv) to take stock of wider arrangements for joint working and to bring forward proposals for change, improvement and development.

The intention was to make substantial progress on CHCP development and also to conclude the review of joint working in the Spring 2009.

Cllr. Coleman welcomed the proposals in the paper and acknowledged the Council's commitment to work positively with the Board to develop the CHCPs. The Chair welcomed Cllr. Coleman's comments.

Mr Sime would welcome the return of joint meetings between CHCP Chairs, Vice-Chairs, the Leader of the Council and Directors from both organisations. He was keen to hear how the Area Partnership Forum could play into the issues highlighted in the paper. Ms Renfrew advised that the review had not commenced and this would be one of the subjects for the Directors and Chairs to discuss at their forthcoming meeting. In addition, there would be involvement with the Partnership Forums at CHCP level.

Mr Williamson asked how the City Council viewed the challenges highlighted in the Board paper and Ms Renfrew replied that the aim was that both organisations took stock of their position on the development of CHCPs and move forward with a joint programme of development work.

Mr McLaughlin could see the clear accountability lines for Community Health Partnerships (CHPs) but was less clear on the CHCP Committee governance arrangements. Mr Divers advised that the Organisational Performance Review arrangements had added significantly to holding the CHCPs to account and the second round of these reviews was now under way. The City Council Scrutiny Committee now received and reviewed CHCP Committee minutes and sought the attendance of Chairs and Directors when required. This was an important development in allowing the City Council's corporate centre to be comfortable with the role and accountability of CHCPs.

In response to questions from Members, Ms Renfrew emphasised that this was not a review of CHCPs but about the next stage of the development of CHCPs and moving forward areas identified as requiring improvements and different ways of working. The budget setting arrangements were clearly a particular issue and further areas for delegation to CHCP Directors need to be an outcome of the review.

Mr P Hamilton advised that the Involving People Committee had agreed to a meeting in December 2008 to support officers working with Public Partnership Forums across NHS Greater Glasgow and Clyde to ensure they were not working in silos and missing opportunities of sharing best practice.

ACTION BY

Mr Cleland asked if the City Council recognised that the work to be undertaken to identify and then address any issues would lead to a process and plan to deliver CHCPs fully consistent with the approved Scheme of Establishment by April 2009. Ms Renfrew referred to Cllr. Coleman's statement that he had welcomed the review and that the first meeting with the CHCP Directors had been arranged for that afternoon. The aim was to move forward a development plan with the Council. If that presented issues the NHS would develop its approach and continue to try and engage with the Council. There was a lot of good work under way in CHCPs and it was the case that this should be built upon with other improvements and developments which should deliver the full potential of CHCPs from April 2009.

Mr Daniels was keen that the focus of the review should not be lost and he welcomed the timescale of more effective working from April 2009. In addition, he strongly supported the re-introduction of the meetings of Chairs, Vice-Chairs and other key players.

Mrs Smith was very interested in the range of comments and level of interest from Non-Executive Directors in this review. She believed that close working with all local authority partners was essential for improving the health and well-being of the population and looked forward to the outcome of the reviews. She was keen that the NHS Board received regular feedback on the progress and Ms Renfrew advised that a progress report would be submitted to each subsequent NHS Board meeting up to April 2009.

DECIDED:

1. That the revised temporary arrangements be noted.

2. That the comments made by Members on the issues raised in the paper be taken into account in taking forward the review. — **Director of of Corporate Planning & Policy/Lead NHS Director – Glasgow CHCPs**

3. That regular progress reports be submitted to future NHS Board meetings and arrangements be made to re-introduce the meetings of Chairs, Vice-Chairs and other key players. — **" " " "**

102. PROCUREMENT MODEL FOR THE CONSTRUCTION OF THE NEW DEVELOPMENT ON THE SOUTHERN GENERAL HOSPITAL SITE

A report of the Director of Acute Services Strategy, Implementation and Planning/Chief Operating Officer – Acute Services Division [Board Paper No. 08/42] asked the Board to receive and approve the Procurement Model to construct the New Adult Acute Hospital, Children's Hospital and New Laboratory Facility on the Southern General Hospital site.

Ms Byrne provided an overview of the work undertaken since March 2008 in developing a procurement model and advised Members of the proposed procurement method to take forward the new hospitals and laboratory developments on the Southern General Hospital site. Eight different models of procurement had been considered at a workshop attended by senior Board officers, Scottish Government representatives, the Board's Legal and Financial Advisers and a number of Technical Advisers.

From the output of the workshop the Project Team completed an option appraisal of all eight procurement models measured against the Board's required criteria of cost, programme, facility and risk. The outcome was the selection of the two-stage Design and Build.

ACTION BY

Ms Byrne then described the process to select potential bidders for the scheme and the output from the market sounding exercise undertaken by the Board's Financial Advisers. She advised that of the nine companies approached, three indicated that they were sufficiently interested in the project to take part in the next stage of the process.

The outcome and procurement model were discussed by the Performance Review Group on 16 September 2008 and at an NHS Board Seminar on 7 October 2008 and Members were content with the intention to present the proposed procurement model to the NHS Board for consideration and approval.

Dr Kapasi sought reassurance that the NHS Board would not be under-writing the bidder costs. Mr Calderwood advised the most appropriate procurement method to achieve the Board's objectives was the two-stage Design and Build process with rapid selection to a single bidder at stage one using the competitive dialogue procedure, with the preferred bidder developing the detailed design in conjunction with the Board at stage two. Therefore, the NHS Board would not take any financial risk on the first stage of the move in identifying a single preferred bidder.

Mr Carson enquired about the impact of the credit crunch and down-turn in the markets. Mr Calderwood advised that as the project was to be Treasury funded and with the Government's intention to increase public sector spending during this period, both should assist in securing a preferred bidder for the project.

DECIDED:

That the Procurement Model, as recommended by the New South Glasgow Executive Board and supported by the Board's advisers, of the two-stage Design and Build process with rapid selection of a single preferred bidder at stage one using the competitive dialogue procedure, be approved.

Director of Acute Services Strategy, Implementation & Planning/Chief Operating Officer - Acute Services Division

103. NEW STOBHILL HOSPITAL – DEVELOPMENT OF SHORT-STAY AND ELDERLY REHABILITATION BEDS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No. 08/43] sought NHS Board approval to an extension of the new Stobhill Ambulatory Care Hospital to accommodate 48 elderly rehabilitation beds and 12 (23-hour) surgery beds.

Mr Calderwood advised that the new Stobhill Hospital had been planned in 3 phases:-

i) Construction of the new Stobhill Ambulatory Care Hospital;

ii) Seven months after the new hospital had been opened, the demolition of specific wards and other buildings and the construction of a new road;

iii) Following the withdrawal of in-patient acute services from the site the creation of a new-build facility attached to the new hospital for elderly rehabilitation beds and the 23-hour surgery beds.

Therefore the approved strategy was to accommodate these beds in the original retained estate for 3 to 4 years pending a later procurement of the new build accommodation. He advised that an opportunity had arisen to revise the strategy in the context of the planned rationalisation of the Stobhill site by late 2010.

ACTION BY

To move forward with the proposal, the Intensive Therapy Unit (ITU) at Stobhill Hospital would require to be re-located during the construction period into a Modular ITU building. This would be specified by the clinical team and procured through the Capital Plan. In addition, the modular unit would be able to be utilised at the Southern General Hospital once vacated at Stobhill Hospital.

The design evaluation of the project had been completed by the Board's Technical Advisers and the clinical teams and the cost model for the unitary charge was consistent with the original terms and conditions set out in the PFI model. The Board's Financial Advisers had confirmed that the terms on offer were within the recognised benchmark. The financial implications were determined as affordable within the Board's Acute Services Strategy cost envelope. The project offered value for money, was affordable and competent under the terms of the existing contract with Glasgow Hospital Facilities Ltd.

Mr P Hamilton asked whether it would be possible to locate the nurse-led chemotherapy service within the new hospital. Mr Calderwood advised that with the in-built additional capacity within the new hospital it may be possible and this would be looked at as one of the options for utilising that capacity.

Dr Benton asked about the elderly rehabilitation beds and the involvement of Social Work and the impact on their budgets. Mr Calderwood stated that the Elderly Planning Group had held discussions on the bed model and agreed the number and resource transfer arrangements. The infra-structure support was already funded and it was now important to get the beds re-provided in better and more modern accommodation.

DECIDED:

1	**That the extension of the new Stobhill Ambulatory Care Hospital to accommodate 48 elderly rehabilitation beds and 12 (23-hour) surgery beds be approved.**	**Chief Operating Officer, Acute Services Division**
2.	**That the Chief Executive and Chief Operating Officer be authorised to conclude the negotiations with Glasgow Hospital Facilities Limited for the extension of the existing PFI agreement be approved.**	**" " "**
3.	**That the Performance Review Group receive a paper on conclusion of the negotiations in order to approve the Board Additional Works Variation to the PFI contract be approved.**	**" " "**

104. PROGRESS REPORT ON C.DIFF ACTION PLAN

A report of the Chief Executive and Medical Director [Board Paper No. 08/44] asked the NHS Board to receive the second draft report on progress in taking forward the Action Plan on Clostridium Difficile (C.Diff.) following the publication of the review produced by the Review Team, Chaired by Professor Cairns Smith. The report had been accompanied by a specific plan of actions which had to be delivered in the period between September 2008 and April 2009. The progress on the Action Plan was being monitored by regular meetings with the Chief Nurse for Scotland and each monthly update was submitted to the Cabinet Secretary for Health and Well-being.

The Board had agreed that Members would see and review the progress against the Action Plan on a monthly basis and this had been achieved by the submission of the Progress Report to the Performance Review Group and NHS Board and made available on the NHS Board's website.

ACTION BY

Dr Cowan took Members through the detail of each of the actions and answered Members' questions in relation to the wider aspects of learning lessons from the Vale of Leven Hospital to other hospitals within NHS Greater Glasgow and Clyde in connection with managing health care acquired infections.

Mr Calderwood advised that from April 2009 funds would be allocated from the capital plan to Senior Charge Nurses for essential maintenance within their areas of responsibility. The Estates Department would then be tasked with carrying out the work requested within a given timescale. Any delays in this process would be escalated up the management structure in order that they are resolved as quickly as possible. The overall intention was that Senior Charge Nurses would have protected management time and training to allow management issues and the development of policies and procedures to be undertaken at ward level. Their job description now included Health Care Associated Infections (HAIs), professional accountability and responsibility.

Mr Cleland asked about rolling out the actions agreed for managing HAIs in the Vale of Leven Hospital across NHS Greater Glasgow and Clyde. It was reported that the range of actions and lessons learned was being applied in the NHS Board's hospitals. Board-wide monitoring of the actions taken and progress made would in future form a key part of a regular report to the NHS Board from January 2009 on implementing the actions and recommendations on HAIs across NHS Greater Glasgow and Clyde. This would follow the requirements of the returns now to be made by all Scottish NHS Boards to the Scottish Government Health Directorates.

In response to Ms Dhir's concern that there should have been more awareness of a trend developing at the Vale of Leven Hospital, Dr Cowan advised that individual cases were identified and managed: however, new monitoring and reporting arrangements now introduced would ensure trends were identified at a much earlier stage.

A review of the infection control management structure would lead to a clarity of responsibilities for HAI from ward level through to the Lead Executive Director (Medical Director).

Mrs Nijjar asked about previous figures for rates of HAI within hospitals: the future reporting to the NHS Board would include a trend analysis covering key areas over the previous year where data was available.

In response to Members' concerns about HAI in hospitals, Dr Cowan advised that multiple resistant organisms were present in structures of buildings and in the community. The move away from staff routinely washing their hands and antibiotic policies had increased the prevalence. Steps were now under way to review policies on visitors and HAI was now a national priority for all clinical staff and managers within the NHS. The actions now being implemented in managing HAI were being regularly monitored and audited to ensure high compliance rates and the increased role and visibility of Senior Charge Nurses was particularly welcomed.

DECIDED:

That the second draft report on progress taking forward the C.Diff Action Plan be received. **Chief Executive/ Medical Director**

105. WINTER PLAN 2008/09

A report of the Director of Acute Services Strategy Implementation and Planning [Board Paper No. 08/45] asked the NHS Board to accept an update on the approach to Winter Planning 2008/09, to approve the Winter Plan for 2008/09 and to agree that it be signed off by the Chief Executive.

ACTION BY

Ms Byrne took Members through the paper on the Winter Plan – 2008/09 and advised that at a national level the Emergency Access Delivery Team had taken over the role of co-ordinating winter planning for 2008/09. A regional event was hosted by NHS Greater Glasgow and Clyde in July 2008 and this was followed up by a national event on 23 September 2008. The key messages which emerged were that winter plans should be single system and should demonstrate inter-agency working across all partners, with a major emphasis placed on the key role of mental health services including addiction services and the availability of in-hours and out-of-hours social services; a robust out-of-hours primary care provision with the full involvement of NHS 24 and that winter demand and capacity issues should also be factored into plans using the experiences of previous years and predictive tools.

The Winter Planning Group agreed that it would meet throughout the year during 2008/09 in light of the pressures and the Executive Group also now meets throughout the year.

Ms Byrne set out the key components of the Winter Plan:-

i) NHS 24 and NHS Greater Glasgow and Clyde out-of-hours services would profile their staffing arrangements based on previous experience and predictive software indications.

ii) The Scottish Ambulance Service would increase resources to meet predictive demand at peak times.

iii) CHCPs would liaise with Social Work departments around availability of social care staff and they would work with the Rehabilitation and Assessment Directorate to ensure links were in place to provide rapid response services for vulnerable older people.

iv) The Acute Services Division would ensure timeous bed management and discharge planning.

v) Additional emergency diagnostics capacity would be established to expedite discharge.

vi) Crisis mental health services would be available as would access to addiction services.

A concern for 2008/09 related to the two 4-day holiday periods during the Festive Season and discussions were under way as to how to alleviate pressure this year given that GP surgeries would be closed over these 4-day periods.

Cllr. Stewart asked about the contact details of on-call arrangements for the new crisis service which had been developed within mental health services. It was confirmed that the finalised material would incorporate the relevant contact details.

Dr Colville advised that the Local Medical Committee supported the Winter Plan and he was aware that GPs were intending to suspend elective appointments in order to cope with the additional pressure of patients requiring to see GPs following the two 4-day breaks. He was keen that as much as possible was put in place to bring to the attention of patients the out-of-hours arrangements during the Festive period. Ms Byrne intimated that a major focus this year was patient education and posters had been developed and would be widely distributed as would the winter planning booklet highlighting the availability of services during the Festive period. The local Public Partnership Forums had also been heavily involved in drawing up this year's arrangements.

ACTION BY

DECIDED:

1. That the update on the approach to winter planning 2008/09 be noted.

2. That the Winter Plan for 2008/09 be approved and it was agreed that it be signed off by the Chief Executive. **Director of Acute Services Strategy Implementation and Planning**

106. REPORT ON PROGRESS WITH REGARD TO THE CAMGLEN/ NORTHERN CORRIDOR TRANSFER IMPLEMENTATION

A report of the Director, South Lanarkshire CHP and Director, North Lanarkshire CHP [Board Paper No. 08/47] provided Members with an update on the work undertaken with regard to the proposed transfer of further accountability planning and governance for the localities of Cambuslang/Rutherglen (Camglen) and the Northern Corridor to NHS Lanarkshire.

Mr Lawrie explained that a Project Board had been established for the implementation and included key stakeholders including Staffside representatives and local GPs. Eight work-streams had been established, each of which had specific Terms of Reference and a Work Plan that identified the issues to be concluded prior to the transfer of responsibility by 1 April 2009.

The key actions for the coming months included:-

i) the development of a legally acceptable Service Level Agreement between NHS Greater Glasgow and Clyde and NHS Lanarkshire in respect of the management of the GMS contract;

ii) the completion of all matters associated with TUPE including terms and conditions to ensure transfer of identified staff on 1 April 2009;

iii) agreement on the final model for the provision of information management and technology services for all professional groups;

iv) agreement to the financial package to transfer, including agreement for the methodology for Service Level Agreements for community services provided to the two localities;

v) the clear identification of resources associated with the headquarters functions which would transfer to NHS Lanarkshire; and

vi) the consistent communication of progress to date with key stakeholders including the public and patients.

Dr Colville advised that the GPs welcomed the fact that their contracts would remain with NHS Greater Glasgow and Clyde (although managed by NHS Lanarkshire) as the patients remained part of NHS Greater Glasgow and Clyde and the patient flows were predominantly to hospitals within Glasgow.

Cllr. Handibode had welcomed the useful and open dialogue that had taken place and he felt it was important to ensure the best outcome of the actions being taken forward rather than being driven by timescale alone.

DECIDED:

That the progress report be noted and that a further update be provided to the NHS Board in the new year. **Director – South Lanarkshire CHP**

ACTION BY

107. DESIGN ACTION PLAN UPDATE

A report of the Director of Acute Services Strategy Implementation and Planning [Board Paper No. 08/48] asked the NHS Board to note progress on the implementation of the Design Action Plan.

Ms Byrne reminded Members that the NHS Board had approved the Design Action Plan in October 2007 and had requested a progress report which related to the actions that were set out for consideration, development and refinement in working towards the publication of a Resource Handbook to support capital project teams and that the Design Action Plan should be tested against a live capital project.

The Capital Planning Group was identified as being responsible for overseeing the implementation of the Design Action Plan and had approved the update for submission to the NHS Board.

She advised that the two projects which were identified against which key concepts and processes outlined within the Design Action Plan were to be piloted were the Barrhead Health and Social Care Centre and the new Maternity Development at the Southern General Hospital. Feedback from this exercise had indicated that despite both projects being initiated prior to the Design Action Plan being in place work had been in line with the key concepts and any gaps were easily identified. In addition, any necessary action would be supported by the Design Action Plan and future preventative action would be directed by the process outline. The Project Managers had felt that the Design Action Plan had been relevant, practical and added value to existing activity and processes.

Ms Byrne highlighted a range of projects, including partnership development which the Design Action Plan had been used to influence, namely, the new Arts Centre in Kirkintilloch which was currently exploring the feasibility for an Arts Health Co-ordinator post to ensure health and well-being was promoted across the building and links to the Kirkintilloch Health Centre; the new Drumchapel Child and Family Health Centre Arts Sub-Group has successfully commissioned a lead Arts Curator to the Design Team in July 2008; the new Stobhill and Victoria Hospitals had a core Arts Programme included in each building and the Maternity Unit project had established an internal Arts Sub-Group.

The Design Action Plan would be incorporated into the procurement of the new Adult/Children's Hospital at the South Glasgow Hospital and this would be included in the tender documentation. Mrs Smith and Cllr. Mackay welcomed the report and approach taken and commended the work undertaken by Ms Byrne and her team.

DECIDED:

That the progress report on the implementation of the Design Action Plan be noted. — **Director of Acute Services Strategy Implementation and Planning**

108. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 08/49] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

ACTION BY

DECIDED:

That the 28 Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

109. PATIENTS' PRIVATE FUNDS – ANNUAL ACCOUNTS 2007/08

A report of the Director of Finance [Board Paper No. 08/50] asked the NHS Board to adopt and approve for submission to the Scottish Government Health Directorates the 2007/08 Patients' Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

Mr Griffin advised that the NHS Board held the private funds of many of its patients, especially those who are in long term residence and who would have no ready alternative to the safe-keeping and management of their funds. Each of the Board's hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service and any funds that were not required for immediate use were invested to generate interest which was then distributed to the patients' accounts based on each individual's balance of funds held.

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

Cllr. Stewart enquired about the impact of the recent down-turn in the markets for Patients' Private Funds. Mr Griffin advised that the funds related to approximately 1,200 patients and it had been decided previously to move away from individual accounts in order to improve the management and investment potential. In light of recent events, he and his colleagues would keep under review the best means by which to hold these accounts to ensure risks to individual patients' sums of money were kept to a minimum.

DECIDED:

1. **That the Patients' Private Funds Annual Accounts for 2007/08 be adopted and approved for submission to the Scottish Government Health Directorates.** **Director of Finance**

2. **That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2007/08.** **Director of Finance**

3. **That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2007/08.** **Director of Finance**

4. **That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board.** **Director of Finance**

110. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No. 08/51] asked the NHS Board to note progress against the national targets as at the end of September 2008.

Mr Calderwood advised that the Scottish Government target was that by March 2011 the total maximum journey time for patients would be 18 weeks from referral to treatment. The Government had set an interim milestone for March 2009 when the maximum wait for an out-patient appointment would be 15 weeks and the maximum wait for admissions for in-patient and day case treatment would also be 15 weeks. As at the end of September 2008 all in-patients, day cases and out-patients had an appointment within 15 weeks and the intention was that from 1 October 2008 all in-patients, day cases and out-patients would be treated within 15 weeks, meaning that the Board had achieved this target six months early.

Mr Daniels welcomed this achievement and congratulated those involved. He continued, however, to be concerned at the cancer wait times and the position in relation to delayed discharges.

Mr Calderwood advised that significant efforts were being made by many staff including individual managers in trying to achieve the cancer wait times, although it was acknowledged that challenges remained in upper GI, head and neck, lung and colorectal cancers. Monthly action plans were in place in an attempt to improve performance and strenuous steps were being taken to identify blockages within the patients pathway to ensure the cancer targets were met across the NHS Board.

Mr Calderwood acknowledged that there had been small numbers of patients whose discharge had been delayed more than the 6 weeks target: however, there appeared to be no specific trend or pattern within any particular local authority that was causing concern. Considerable progress had been achieved over the last year in reducing the number of patients delayed in hospital awaiting discharge and Cllr. Mackay indicated that there was no reduction in funding within Renfrewshire Council where there was a slight increase in those waiting over the 6 week target. The NHS Board would continue to work with its local authority partners in an effort to reduce the small number of patients who were waiting beyond the 6-week target.

Dr Kapasi enquired about the diagnostic waiting times and the potential cumulative effect of waiting for a range of diagnostic tests. Mr Calderwood advised that the target was based on 6 weeks for each of the 8 different tests: however, the overall target of 18 weeks from referral to treatment covered the concerns highlighted by Dr Kapasi.

Dr Kapasi raised the maximum wait from GP referral through to rapid access chest pain clinic to cardiac intervention of 16 weeks. Mr Divers advised that whilst this was the target, many patients waited a maximum of 3 to 4 days and some as little as 2 hours depending on their clinical assessment and clinical need.

Professor Barlow welcomed the significant improvements that had been made to wait times over the last 2 to 3 years and was confident that further reductions in wait times would be forthcoming.

NOTED

111. QUARTERLY COMPLAINTS REPORT: 1 APRIL 2008 – 30 JUNE 2008

A report of the Head of Board Administration, Chief Operating Officer, Acute Services Division and Lead Director, CHCPs (Glasgow) [Board Paper No. 08/52] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 April to 30 June 2008.

ACTION BY

Mr J Hamilton highlighted the continued disappointing performance of approximately 50% of complaints received and completed within 20 working days against a national target of 70%. He highlighted the restructuring of the complaints function within the Acute Services Division and that the improvements of cross-cover, skill-mix of staff, senior support and staff aligned to support Directorates leading to greater familiarity with specific Directorates had already improved response times with 60% of complaints being responded to within 20 working days in July 2008 and 57% in August.

In addition, he highlighted the service improvements identified within the paper and also that the Independent Advice and Support Service first Annual Report had now been made available and would be sent to Members for information. **Head of Board Administration**

Mr Daniels commented that he continued to be disappointed at the poor performance in dealing with complaints within the national target and he felt it was a matter of concern for the NHS Board.

Dr Benton asked what action was being taken to address the significant number of complaints that related to attitude/behaviour of staff and Mr Hamilton advised that the training programme for frontline staff was informed by the trends identified within the Quarterly Complaints Report.

Mr Cleland advised that the Clinical Governance Committee reviewed at its meeting the outcome and recommendations from the Ombudsman Reports to ensure that each of the recommendations was fully implemented and also that lessons were learned across the NHS Board, particularly where the Ombudsman's Office had highlighted specific trends.

Dr Kapasi enquired about the number of complaints received within the family health services and how these were reported. Mr Divers advised that routine collection of this data was in place as the Information Services Division published annually the total number of complaints raised against GPs and Dental Practitioners. Mr Hamilton agreed to report back to the Board on how this information could be shared as part of the Quarterly Complaints Report. **Head of Board Administration**

It was recognised that greater efforts were required to ensure that the Acute Services Division and the individual partnerships improved their performance in complaint handling and the Board was keen to see early improvements in this area. **Head of Board Administration**

NOTED

112. INVOLVING PEOPLE COMMITTEE MINUTES: 4 AUGUST 2008

The Minutes of the Involving People Committee meeting held on 4 August 2008 [IPC(M)08/04] were noted.

NOTED

113. PHARMACY PRACTICES COMMITTEE MINUTES: 1 SEPTEMBER 2008 AND 9 SEPTEMBER 2008

The Minutes of the Pharmacy Practices Committee meetings held on 1 September 2008 [PPC(M)08/18] and 9 September 2008 [PPC(M)08/19] were noted.

NOTED

ACTION BY

114. AUDIT COMMITTEE MINUTES: 9 SEPTEMBER 2008

The Minutes of the Audit Committee meeting held on 9 September 2008 [A(M)08/05] were noted.

NOTED

115. PERFORMANCE REVIEW GROUP MINUTES: 16 SEPTEMBER 2008

The Minutes of the Performance Review Group meeting held on 16 September 2008 [PRG(M)08/05] were noted.

NOTED

The meeting ended at 12.40 p.m.

Greater Glasgow & Clyde NHS Board

NHS Board Meeting
21 October 2008

Board Paper No. 08/42

Report of the Chief Operating Officer and Director of Acute Services Strategy, Implementation and Planning

Procurement Model for the Construction of the New Development on the Southern General Hospital Site

Recommendation:

Board Members are asked to receive and approve the Procurement Model to construct the New Adult Acute Hospital, Children's Hospital and New Laboratory Facility on the Southern General Hospital site. The recommendation is supported by the Board's Legal, Financial, Technical and Procurement Advisers.

1. Purpose of Paper

This paper provides both an overview of the work undertaken since March 2008 in developing a procurement method and sets out the proposed procurement method to take forward the new hospitals and laboratory developments on the Southern General Hospital site.

The Board embarked upon a plan to determine how best to deliver the new hospitals and laboratory developments on the Southern General Hospital campus prior to the approval of the Outline Business Case (OBC). This plan included taking soundings from a range of Technical Advisers known to the Board and seeking their initial thoughts on the best way to deliver the new facilities.

Following on from this, Senior Board Officers, supported by the Board's Legal and Financial Advisers and with Scottish Government representation, held a formal workshop with a number of Technical Advisers to carry out further analysis and evaluation to develop the most appropriate procurement method.

The workshop considered eight different models of procurement, these were as follows:

- Traditional
- Management Contracting
- Construction Management
- Single Stage Design & Build
- Two Stage Design and Build
- Design, Build and Operate
- Alliancing
- Prime Contracting

From the output of the workshop the project team completed an option appraisal of all eight procurement models measured against the Board's required criteria of cost, programme, quality and risk. The outcome of the option appraisal was the selection of the Two Stage Design and Build as the most appropriate option. This option would meet the Board's criteria and also provide an early estimate of costs. As part of the 2 stage Design and Build procurement method a selection process of 3 bidders (or more) reducing to 2 at the first selection point was adopted. A competition

between the two selected bidders will lead to a final selection of a preferred bidder and then the appointment of a contractor of a constructor/designer.

In order to test this approach to procurement, the Board's Financial Advisers (Ernst & Young) undertook a market sounding exercise to test out attractiveness and robustness of the proposed procurement model with key players in the market.

The aim of the Market Sounding exercise was to establish the market view on a) how the New South Glasgow Hospitals Project should be procured and b) what the market bidding intentions may be. It was also to determine those factors which would reduce the attractiveness of the project and the market views on how these issues should be addressed.

Ernst & Young have set out the findings of the market consultation and outlined a procurement method that it is believed, will maximise interest from potential bidders and achieve the Board's key objective of identifying a procurement process which:

- allows for an appropriate degree of design development discussions to occur prior to the appointment of a single contractor;

- offers the possibility of market innovation in the design development process;

- provides for competition up to the point where the Guaranteed Maximum Price is largely established;

- meets the delivery timescales.

The points to note from the process are as follows:

- Of the nine companies approached, three indicated that they were sufficiently interested in the project to take part in the consultation process;

- Given the size and complexity of this project there is risk of significant abortive costs being incurred by unsuccessful bidders. Two of the three companies who have an interest in the project have estimated the bid cost between £10m-£20m and have indicated that this sum at risk may prevent their participation. This would significantly reduce the competitive tension available to drive innovation and provide value for money;

- In order to enhance the market attractiveness of the project the companies identified a range of options. These included the Health Board underwriting some, if not all, of the bid costs for the unsuccessful bidders or the rapid selection of a single preferred bidder reducing the initial bidder input and therefore the bid costs at risk;

- In developing the revised procurement process the risks and opportunities of applying different procurement paths were analysed. The key factors are:

  a) making sure there is sufficient market interest by reducing the risk at the outset thereby achieving value for money through competition. A Target Price and Guaranteed Maximum Price Contract and process which reduces the number of bidders to one at the 1st stage with a reasonable level of design requires significantly lower bidder input, and therefore bid costs at risk, than producing a fully detailed design;

  b) another key factor is the nature of the procurement selected. The pros and cons of both the restricted and competitive dialogue process were analysed. The competitive dialogue route was considered to provide the degree of dialogue necessary to achieve design innovation, final contract form and financial arrangements to meet the Board's affordability profile;

- The outcome of the procurement analysis therefore proposes that the most appropriate procurement method to achieve the Board's objectives is a two stage Design and Build process with rapid selection to a single preferred bidder at stage one using the competitive dialogue procedure. At stage two the preferred bidder develops the detailed design in conjunction with the Board.

The project team then presented the final procurement model to the New South Glasgow Executive Board (NSGEB). The NSGEB approved the proposed procurement model but as a final test of its appropriateness and robustness requested the project team test the model with the newly appointed Technical Advisers (Currie & Brown) and Procurement Advisers (Partnership UK). A workshop of all advisers was held on 1st October to go through the model in detail and to identify any critical risks or weaknesses with the procurement model.

The outcome of the workshop was that the model was proved to be appropriate and robust to deliver the Board's requirements. From the workshop the group identified a number of critical risks which are the responsibility of the project team and the Board's Advisers to control and mitigate as part of the Risk Management Strategy for the project.

The Project Team, supported by advisers and other Board Officers, have carried out a robust process to develop, what is proposed as, the most appropriate delivery vehicle for the construction of a New Adult Hospital, New Children's Hospital and Laboratory Facility on the Southern General Hospital Campus.

The Director of Acute Services Strategy Implementation and Planning and the Chief Operating Officer presented the procurement model to the Board's Performance Review Group on the 16th September for information. Members welcomed the approach taken and were content with the next steps outlined to develop the procurement model for the new hospitals and laboratory development.

The Project Director for the New South Glasgow Hospitals Development and the Board's Technical and Financial Advisers presented the proposed procurement model to NHS Board Seminar on the 7th October. The presentation set out:

- the background and process followed in formulating the proposed procurement model, highlighted the outcome of the Market Sounding Exercise;

- the outcomes of the workshop on 1 October 2008 and set out the detail of the Procurement Model.

Board members raised a number of issues with regard to the proposal namely that:

- there should be appropriate risk management arrangements in place to inform the Board at the highest level that all risks are being managed appropriately;

- Audit Scotland participated in the governance structure overseeing the project;

- the cost implications and cost guarantees were managed appropriately by Board Officers:

- there is a plan in place to maximise and sustain a positive impact with the community regarding employment opportunity during and after construction.

Board members agreed that the proposed procurement model be submitted to the NHS Board on 21st October for consideration and approval.

EMBARGOED UNTIL DATE OF MEETING

Recommendation:

Members are asked to receive and approve the attached Procurement Model to construct the New Adult Acute Hospital, Children's Hospital and New Laboratory Facility on the Southern General Hospital site. The recommendation is supported by the Board's Legal, Financial, Technical and Procurement Advisers.

Robert Calderwood, Chief Operating Officer
[redacted]

Helen Byrne, Director of Acute Services Strategy Implementation and Planning
[redacted]

NHSGG&C(M)09/1
Minutes: 1 - 27

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 24 February 2009 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Professor D Barlow
Dr C Benton MBE
Mr G Carson
Dr L de Caestecker
Mr R Cleland
Councillor J Coleman
Dr D Colville (to Minute 13)
Mrs A Coulthard (to Minute 9)
Dr B Cowan
Ms R Crocket (to Minute 14)
Mr P Daniels OBE
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Dr M Kapasi MBE
Councillor D MacKay
Councillor J McIlwee
Mrs J Murray
Mrs R K Nijjar
Councillor I Robertson
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE
Councillor A Stewart
Councillor D Yates

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

Mr G Archibald	..	Director of Emergency Care and Medical Services (to Minute 6)
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr T Eltringham	..	Head of Health and Community Care, East Renfrewshire CHCP (to Minute 12)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director of Mental Health Partnership
Mr A Lawrie	..	Director of South Lanarkshire CHP (to Minute 16)
Mr N McGrogan	..	Head of Community Engagement and Transport
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Councillor J Handibode, Mr I Lee, Mr G McLaughlin and Mr B Williamson.

2. CHAIR'S REPORT

(i) Mr Robertson had attended the Glasgow City Community Health and Care Partnerships (CHCPs) Management Team Event on 17 December 2008. This had been a successful meeting in terms of formalising the direction of travel for Glasgow City CHCPs and fine-tuning their Scheme of Delegation and Scheme of Establishment.

(ii) Throughout January 2009, Mr Robertson had visited many hospital sites including the Princess Royal Maternity Hospital, Gartnavel Royal Hospital, Royal Alexandra Hospital, Blawarthill Hospital, Beatson West of Scotland Cancer Centre, Golden Jubilee National Hospital and Canniesburn Plastic Surgery Unit (Glasgow Royal Infirmary). Over and above this, he had also attended the formal openings by the Cabinet Secretary of Possilpark Health Centre, the Emergency Dispatch Function (based at Caledonia House), Plean Street Centre for Health and Care in Yoker and the Aroma Coffee Bar based at Glasgow Royal Infirmary.

(iii) On 29 January 2009, Mr Robertson had met with Professor Barry Gusterson (University of Glasgow) and on 16 February 2009, Professor Sir Michael Bond with whom he had discussed the fundraising appeal launched to fund the Beatson Translational Research Unit (the third element of cancer service improvement work and where there were direct links between research and patient care).

(iv) On 16 February 2009, Mr Robertson had participated in the "Industry Day for the South Glasgow Hospitals" at Hampden.

NOTED

3. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers had attended the launch of the staff survey results at the Beardmore Hotel on 21 January 2009. An action plan was being taken forward to address the issues arising from this.

(ii) On 23 February 2009, Mr Divers had attended the first part of the Scottish Government's annual gathering of public sector Chief Executives. This was chaired by the Cabinet Secretary for Finance and Sustainable Growth.

NOTED

4. MINUTES

On the motion of Councillor D Yates, seconded by Mr P Hamilton, the Minutes of the meeting of the NHS Board held on Tuesday, 16 December 2008 [NHSGG&C(M)08/8] were approved as an accurate record and signed by the Chair.

NOTED

5. MATTERS ARISING FROM THE MINUTES

The rolling action list of Matters Arising was circulated and noted.

NOTED

6. VISION FOR THE VALE OF LEVEN HOSPITAL : OUTCOME OF CONSULTATION

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 09/01] asked the NHS Board to receive the outcome of the Vale of Leven Hospital consultation process and the responses submitted and, thereafter, consider the recommendations contained within the paper.

The NHS Board was also asked to note that plans for the Alexandria Medical Centre, which was a capital project, were being taken forward through a separate process for approval by the Scottish Government Capital Investment Group.

Ms Byrne set out the background to the consultation process in relation to the vision for the Vale of Leven Hospital site. She described, in detail, the engagement and consultation process that had been undertaken and provided a summary of the responses received, both in writing and at public meetings and drop-in sessions and highlighted the NHS Board's considered responses to this feedback.

She reminded the Board that the vision for unscheduled medical care that had been consulted upon was developed following the Independent External Review of Anaesthetics undertaken in July and August 2008. She summarised the conclusions of that review as follows:-

- 24 hour Anaesthetics provision was not sustainable on the Vale of Leven Hospital site.

- A GP led model of unscheduled medical care should be developed at the hospital.

Ms Byrne outlined the key proposals and explained that the impact identified by these changes on patient activity in the hospital was highlighted and had been included in the vision document and presented at public meetings.

Ms Byrne explained that similar themes had been raised in the written responses, public meetings and the drop-in sessions. She led the NHS Board through the six themes as follows:

- The vision and consultation
- Unscheduled medical care
- Stroke services and rehabilitation
- Mental health services
- Repatriation of planned care services
- Access and transport

She outlined the NHS Board's position on the responses received explaining that the recommendations translated the vision that was consulted upon for the Vale of Leven into a deliverable and realisable opportunity for the future. It would see a large increase in the number of patient episodes delivered on the site. Whilst there would be a reduction in inpatient bed numbers and an associated reduction in overall staffing numbers at the hospital, the NHS Board's Organisational Change Policies would be applied which ensured that there would be no compulsory redundancies required. The developments in relation to planned care would also provide new employment opportunities at the hospital.

Based on comments made during consultation, Ms Byrne made reference to the following points regarding the recommendations being made:

- It had been concluded that a Consultant led model of care, in which GP principals and GP specialty trainees would be key partners, represented the best model of care which could be sustained in future, without the requirement for anaesthetic support. The key elements of the model would see a Consultant Physician on site at the Vale of Leven Hospital throughout the day time period on Monday to Friday each week, with a post-receiving round of new admissions plus "troubleshooting" of any other ill patients taking place on a Saturday and Sunday. GP principals would lead the onsite medical cover provided outwith these periods and an innovative GP specialty training rota would anchor the junior/middle grade medical staff support.

This model moved to address significantly the concerns and issues raised by the Physicians and the two Royal Colleges. For that reason, it was recommended that the NHS Board approve the development of that model of care which retained the majority of the current unscheduled medical care activity at the Vale of Leven Hospital without the provision of 24 hour Anaesthetic cover.

- The provision of much improved community and primary care mental health services over the last year and, in particular, the further extension of the crisis service from January 2009 had resulted in a significant reduction in the number of admissions to the Christie Ward. The current level of adult admissions ran at around twelve per month. This level of admissions was under the level anticipated for a twelve bedded ward. When the full impact of the improved community service was delivered, the number of admissions would reduce further, lengths of stay would reduce and it was anticipated that within 12 months there would no longer be a viable admission unit. Careful monitoring of the impact of community services would continue: it was expected that the Christie Ward would close within 12 to 18 months and the beds transfer to Gartnavel Royal Hospital.

- The proposals in relation to introducing new and expanded planned care services proved uncontroversial during consultation. These would require investment in the Vale of Leven site in terms of equipment and staff. It was recommended that the repatriation of these services in relation to planned care was approved by the NHS Board as an essential part of the wider vision and corresponding recommendations outlined. Similarly, it was recommended that the proposal to develop palliative care services at the Vale of Leven be approved.

If the NHS Board approved the recommendations outlined, they would be subject to a decision by the Cabinet Secretary. Following a discussion with the Cabinet Secretary, the next steps would be to develop a Capital Investment Plan for the hospital to ensure that services could be delivered from appropriate accommodation on an ongoing basis. It was anticipated that this Capital Investment Plan would be developed within nine months. As part of this Capital Plan, an overall vision for the physical layout of the site would be developed and this would incorporate the plans for the new Alexandria Medical Centre. In relation to timescales for implementing the changes described by Ms Byrne, a process of implementation would commence from no more than one year after a decision had been taken by the Cabinet Secretary.

Mr Robertson acknowledged the work of all those involved in progressing this consultation exercise to reach this stage. He particularly thanked Mr P Hamilton who had chaired all nine of the public meetings.

Councillor Robertson also recorded his thanks and welcomed the model and vision especially as it provided the local community with certainty over the future of the hospital. He did not agree, however, with the recommendation that would see the closure of the acute adult mental health admission service provided from Christie Ward.

In response, Mrs Hawkins noted that the average length of stay within the Christie Ward was much higher than other similar wards within NHSGGC. The figures had demonstrated usage of the Christie Ward was declining and this was to be expected as community services developed in the area. She reiterated the NHS Board's vision to maximise community services thereby minimising admissions to mental health services within any hospital.

She explained that there would be careful recording of the use and impact of local community and primary care services with regular reporting to the Clyde Modernising Mental Health Programme Board and the Mental Health Partnership Committee and this would inform the ultimate date of transfer of the existing Christie Ward service to Gartnavel Royal Hospital in twelve to eighteen months time. Mr P Hamilton welcomed this clarification and supported the recommendation.

Mr Divers confirmed that a reducing pattern of usage within the ward was already apparent and he was confident that the NHS Board could provide a safe and sustainable service in the community as local community services improved. Monitoring the declining usage would be key to establishing the ultimate closing date of the Christie Ward. He re-emphasised a point made earlier, in that it was important to bring certainty to the community regarding the totality of the vision and to be clear about what services would be provided at the Vale of Leven Hospital longer term. As such, it was important to conclude now that the Christie Ward would not remain viable beyond the short term.

Councillor MacKay welcomed the work that had been carried out in setting a positive scene and future for the Vale of Leven Hospital. He noted that the "north of the river" option had been explored thoroughly as this had been raised at many of the public meetings. It was concluded that this was not a practical or deliverable solution either financially or in staffing resource terms. He asked whether a further public consultation would be required in two years time if the NHS Board did not today make a decision on the acute adult mental health admission service provided from Christie Ward. Mr Divers confirmed that this would indeed be the case and it was acknowledged that this would add uncertainty to the community rather than being clear about the NHS Board's intentions as they stood today.

Mr Carson commended the intention to maintain a stroke rehabilitation service at the Vale of Leven Hospital – to which patients would transfer as soon as it was clinically appropriate. This reflected the belief that it was desirable for rehabilitation to take place as locally as possible as soon as was possible. His comments were especially relevant as he referred to a recent newspaper article which ranked the Southern General Hospital Stroke Unit fourth in Europe for the number of patients treated this way.

In response to a question from Ms Dhir, Mr Divers confirmed that the plans for the Alexandria Medical Centre had been included within the document as, although it was a capital project being taken forward through a separate process for approval by the Scottish Government Capital Investment Group, it had been helpful in terms of highlighting service provision within the Vale of Leven Hospital campus and for illustrating the overall development plan.

It was anticipated that the new Alexandria Health Centre would be operational by late 2012/early 2013 and this would be discussed further at the Performance Review Group meeting held in March 2009.

In response to a question from Mr P Hamilton, Mr Divers confirmed that a commitment had been made to invest and improve the fabric of the Vale of Leven Hospital building. Work would also continue with the Scottish Ambulance Service to finalise the discussions about the resource implementations of meeting the additional patient journeys and conclusions would be reported publically.

Councillor Robertson moved an amendment to the recommendation concerning the acute adult mental health admission service currently provided from Christie Ward transferring to Gartnavel Royal Hospital in 12/18 months time. He suggested this be reworded to read as follows:

"Accept the majority views expressed by the local community and other stakeholders through the consultation process and approve the retention of Adult Acute Mental Health Services within improved accommodation at the Vale of Leven Hospital as detailed in Option 1 of the consultation document. Acknowledge the commitment to continue to develop community based services. In addition, recognise the potential impact visiting relatives and carers may have on patients' recovery through increased accessibility of retention of local services at the Vale of Leven.

The NHS Board was also asked to note the concerns expressed by local GPs regarding a further one year delay in the provision of the new Alexandria Health Centre".

Councillor Robertson sought a seconder. No seconder was found, therefore, the proposed amendment fell. Councillor Robertson asked that his dissent be recorded in relation to the recommendation to close the Christie Ward in 12/18 months and transfer the service to Gartnavel Royal Hospital.

DECIDED - Subject to Councillor Robertson's dissent as noted above :

- That the outcome of the consultation process and responses submitted be received.

- That the conclusion from the consultation (and two earlier external reviews) that the level of Anaesthetic Service required to support the current model of unscheduled medical care was not sustainable be approved. — **Director of Acute Services Strategy Implementation and Planning**

- That the development of alternative arrangements for the provision of unscheduled medical care at the Vale of Leven Hospital that would sustain approximately 70% of the current activity without the continued provision of anaesthetic cover be approved. — "

- That alternative arrangements for the provision of local rehabilitation services be approved. — "

- That the retention of elderly acute admission mental health services at the Vale of Leven site and their integration with continuing care mental health services currently housed in Dumbarton Joint Hospital be approved. — "

- That the closure of the acute adult mental health admission service provided from Christie Ward with the transfer of this service to Gartnavel Royal Hospital in twelve to eighteen months time be approved. That there be careful monitoring of the use and impact of community and primary care services with regular reporting to the Clyde Modernising Mental Health Programme Board and the Mental Health Partnership Committee and this would inform the ultimate date of transfer. — "

- That the repatriation of 18,350 planned care attendances in relation to Urology, Ophthalmology, Rheumatology, Renal Dialysis and Oral Health Services to the Vale of Leven site and the future development of a palliative care service be approved. — "

- That the recommendations be submitted for decision by the Cabinet Secretary for Health and Wellbeing be noted.

- That the plans for the Alexandria Health Centre, which was a capital project and being taken forward through a separate process for approval by the Scottish Government Capital Investment Group be noted.

7. REVIEW OF NHS CONTINUING CARE FOR FRAIL ELDERLY

A report of the Chief Executive and Director of Rehabilitation and Assessment [Board Paper No 09/02] updated the NHS Board on the discussions and contact with St Margaret's of Scotland Hospice since the NHS Board meeting in April 2008.

Mr Divers outlined the background to the review of planning for frail older people and explained that the planning assumptions regarding frail elderly continuing care beds remained valid and there remained more NHS continuing care beds in use than were required to meet the needs of the population. As such, it was recommended that the NHS Board agree to the further reduction in NHS continuing care beds proposed at St Margaret's and in South Glasgow.

The proposed redevelopment of Blawarthill was a holistic service solution to the needs of residents of West Glasgow including social and disabled housing and additional care home beds of which there was a shortage in that sector of the city.

It had been suggested that the NHS beds at Blawarthill should be closed or used for these different types of care. To use these beds as social care would leave the NHS beds isolated and difficult to staff safely and would also lead to a disproportionate number of social care beds in that part of the city. The suggested shift of NHS continuing care of older people with mental health problems to St Margaret's was made in recognition of St Margaret's desire to stay as a provider of NHS care. It was not part of the NHS Board's extant mental health strategy and was proposed specifically as a means to find an acceptable way forward with St Margaret's.

Mr Divers explained that to close thirty NHS beds at Blawarthill would require further public engagement and consultation. Most particularly, it would involve the NHS Board moving away from the decision to which it was committed following public consultation in 2000 and abandoning the commitment it had made to develop the Blawarthill site in conjunction with the key partners. There was no need nor justification to move away from that decision taken in 2000 – it remained the appropriate strategic decision for the years ahead.

The current accommodation at Blawarthill was, however, largely in shared rooms whereas St Margaret's was able to provide mainly single room accommodation. It was, therefore, recommended that the redevelopment of Blawarthill continue and that the transfer of responsibility for continuing care frail elderly services from St Margaret's be linked to the opening of the new 100% single room accommodation at the hospital. St Margaret's would be given formal written notice with terms linked to that development, which was expected to be available early in 2012.

Mr Divers commented that St Margaret's was fundamentally opposed to considering any option for change other than an expansion of the hospice beds. They did not consider that providing care beds with nursing to be compatible with their core values and maintenance of their hospice status.

As part of its palliative care planning, the NHS Board was currently concluding a needs assessment regarding palliative care for non malignant conditions. This would form part of the NHS Board's response to the recently launched National Action Plan for Palliative and End of Life Care in Scotland. St Margaret's proposed expansion of inpatient beds required to be viewed in light of that piece of work and in the context of other NHS Board priorities for this type of care. It was, therefore, not possible for the NHS Board to respond to the proposal at this stage.

The proposal also had significant implications for other specialist palliative care providers and would require detailed discussion with them and other relevant clinicians. Planning for palliative care was conducted through the Managed Clinical Network. It was, therefore, recommended that the proposed expansion in palliative care beds be considered by the Managed Clinical Network for Palliative Care as part of its ongoing response to "Living and Dying Well".

Mr Divers confirmed that the NHS Board would continue to work with St Margaret's to encourage them to consider options for development should the palliative care proposal not be pursued - in order to ensure that the facilities there continued to be available for the population and to ensure that the current level of palliative care was not jeopardised.

In this regard, Mr Robertson confirmed that he had met with the Chairman of St Margaret's on 19 February 2009 and St Margaret's continued to decline to take part in any assessment of a move to a different model of care other than their proposed expansion of palliative care.

In response to a question from Mr Cleland, Mr Divers confirmed that St Margaret's position was that they wished to retain wards for palliative care development only and, as such, were not prepared to enter into discussions regarding the other options. In commending the work that was undertaken at St Margaret's Hospice, Ms Dhir was disappointed that St Margaret's was not prepared to collaborate as a partner in rejecting consideration of the proposals made by the NHS Board.

For the avoidance of any doubt, Ms Renfrew highlighted two different strands of work, namely, the future of palliative care and NHS continuing care. She explained that both were not contingent on each other - rather they had separate processes and interdependences as described earlier.

Councillor Stewart referred to paragraph 6.1 of the Board paper showing the indicative financial impact of the options. For Option 1, it was her understanding that the NHS Board was being asked, under the recommendations, to issue formal notice to St Margaret's that the NHS Board would not require St Margaret's to provide NHS continuing care once the new wards at Blawarthill Hospital were open in 2012. It was her view that, at present, the NHS Board did not know if option 4 "Additional Palliative Care" was a viable option until the NHS Board concluded a needs assessment regarding palliative care for non malignant conditions and had detailed discussions with specialist palliative care providers and other relevant clinicians. Furthermore, she noted, the NHS Board had received thirty-five written representations from the public and the Scottish Government Petitions Committee a petition of over 100,000 signatures. Councillor Stewart commented that this demonstrated the strength of feeling of the public to secure the future of St Margaret's. She concluded by adding that if the NHS Board agreed to the recommendations, St Margaret's and the public would be entering into a period of uncertainty and this would cause further concern.

It was noted that Mr Bannon had submitted comments for information and consideration

Councillor Stewart moved a motion to delay the decision-making until all the detailed work for Option 4 was completed in order that all viable options could be fully considered. The motion was seconded by Councillor Robertson. A vote was, therefore, conducted as follows:-

- In favour – 3 Board members
- Against – 20 Board members

The motion fell and the NHS Board decided the following:-

DECIDED:

- That the implementation of the shift in the balance of care be continued be agreed. **Director of Rehabilitation and Assessment**
- That the NHS Board's commitment to the redevelopment of Blawarthill Hospital site be reaffirmed. **Director of Rehabilitation and Assessment**
- That the outcome of the recent discussions with St Margaret of Scotland Hospice Board be noted.
- That formal notice to St Margaret's that the NHS Board would not require St Margaret's to provide NHS continuing care once the new wards at Blawarthill Hospital were opened, targeted for early 2012 be issued. **Director of Rehabilitation and Assessment**
- That the issue of St Margaret's expanded provision of palliative care within the thirty beds currently designated for continuing care should be considered by the Managed Clinical Network for Palliative Care as part of the NHS Board's ongoing response to "Living and Dying Well" be noted. **Director of Rehabilitation and Assessment**

8. HEALTHCARE ASSOCIATED INFECTION – C.DIFF ACTION PLAN

A report of the Medical Director [Board Paper No 09/03] asked the NHS Board to note the latest update on the NHSGGC action plan and the follow-up review report from the Independent Review Team.

Dr Cowan recounted that the NHS Board had previously reviewed the on-going progress against the recommendations set out in the initial report from the Independent Review Team. One of the key recommendations was that the Review Team undertake a further review six months after the initial review. This further review took place during December 2008 and January 2009 and Dr Cowan led the NHS Board through their report which had been published on 10 February 2009.

Dr Cowan explained that the specific actions had been split into the following key areas:-

- Governance
- Facilities
- Clinical Leadership
- Surveillance
- Education
- Communication
- Finance

In relation to the follow-up report by the Independent Review Team, it confirmed that the recommendations had been systematically addressed by the NHS Board and monitored through monthly progress reports. As such, a much improved and more direct organisation for the control of infection was being implemented and would be fully integrated with the rest of the NHS Board's area by March 2009 – supported by a number of key appointments.

In response to a question from Mrs Nijjar, Dr Cowan confirmed that the dress code guidance had followed national guidance.

NOTED

9. HEALTHCARE ASSOCIATED INFECTION

A report of the Medical Director [Board Paper No 09/04] asked the NHS Board to receive the first formal monitoring report on Healthcare Associated Infection (HAIs) within NHSGGC.

Dr Cowan explained that the Monitoring Report to the NHS Board was following a requirement of the National HAI Task Force Action Plan and the report presented data on the performance of NHSGGC on a range of key HAI indicators at national and individual hospital site level.

Dr Cowan outlined the NHS Board's position and performance in relation to:-

- S. aureus bacteraemias (HEAT Target)
- C.difficile
- Surgical site infections
- Hand hygiene compliance
- Monitoring of cleaning services.

Dr Cowan led the Board through the data as it was presented at both national and hospital level and summarised the following points:-

- If current trends were maintained, NHSGGC would achieve the target of a 35% reduction in S. aureus bacteraemia by 2010.

- The National Report published on 14 January 2009 showed that NHSGGC was below the national mean and that there had been a reduction of C.difficile in 2007/2008. The annual overall rate for NHS Scotland per 1000 occupied bed days was 1.29. The rate for NHSGGC was below this and was reported as 1.08 for the same time period.

- The Surgical Site Infection rates in NHSGGC were below the national average for all procedures reported apart from hip arthroplasty.

- NHSGGC had demonstrated a steady rise in compliance during the national audit periods from a 62% baseline in February 2007 to achieve the 90% target in September 2008 and 92% in January 2009.

- All areas within NHSGGC scored green (>90%) in the most recent report on the National Cleaning Specification.

Mr Sime referred to hand hygiene compliance and noted, in particular, the disappointing rate for medical staff. Dr Cowan responded by confirming that although compliance was lower for this group of staff, work was ongoing to raise awareness and to ensure hand hygiene was being addressed fully at Local Governance meetings. Professor Barlow recognised that there were different styles and practices across the medical professions, be it surgeons or physicians. Given that physicians were often a non invasive profession, it was important to also ensure compliance within this group of staff. It was paramount to change ways of working and, in this regard, Professor Barlow referred to a new module delivered by Universities to all medical students to address this subject.

Dr Colville asked how this would impact on primary care and Dr Cowan confirmed that healthcare associated infection monitoring would include primary care and, as such, a strategy would be distributed throughout General Practice shortly. Dr Colville welcomed this and commented that an increased length of stay in any hospital increased chances of infection and acknowledged that when a patient left hospital any infection often disappeared quickly.

Medical Director

In response to a question from Mr Cleland, Dr Cowan confirmed that a survey was underway concerning visitors/members of the public and their compliance with hand hygiene.

NOTED

10. WINTER PLAN 2008/09

A report of the Director of Acute Services Strategy Implementation and Planning [Board Paper No 09/05] asked the NHS Board to receive an update on Winter Planning 2008/09 including a progress report on how the plan had worked over the extended festive period and into the New Year.

Ms Byrne confirmed that, given the extreme pressures on acute services, NHS 24 and GP Out of Hours Services in the early part of December 2008, it was felt that NHS Greater Glasgow and Clyde performed well over the festive period. There were two contributing factors she wanted to highlight:

(1) The recent co-location of NHS 24, Out of Hours Services and the Scottish Ambulance Service at Caledonia House.

(2) Working together, across the system, in the pre-winter period.

January 2009 proved to be a demanding month for acute services within NHSGGC recording a figure of 97% compliance against the A & E target. Similar pressures had been acknowledged by other NHS Board areas and it was anticipated that the national figure for January 2009 would be 96% compliance. In terms of February 2009, the start of the month had seen higher compliance figures for the NHS Board than in either December 2008 or January 2009 and there were encouraging signs that bed pressures may be relaxing slightly. Ms Byrne confirmed that the Emergency Care and Medical Services Directorate would continue to work collaboratively with colleagues in other Directorates and key provider agencies to ensure the NHS Board returned to 98% compliance as soon as possible.

Ms Byrne recorded that the Winter Planning Group would meet in April 2009 to assess the NHS Board's performance in 2008/09 and begin planning for 2009/10. This year would again be a four day holiday period. Messages to share with the National Winter Plan Group would also be agreed.

Councillor MacKay welcomed the report and wondered if there was sufficient awareness of the minor ailments services throughout Greater Glasgow and Clyde. Ms Byrne reported that David Walker (Director, Inverclyde CHP and CHCP Lead for Winter Planning) was reviewing all aspects of the Winter Plan from a primary and community care perspective and she would ensure that this be factored into that review.

Director of Acute Services Strategy Implementation and Planning

NOTED

11. THE DIRECTORATE OF FORENSIC MENTAL HEALTH AND LEARNING DISABILITY

A report of the Director of the Mental Health Partnership [Board Paper No 09/06] asked the NHS Board to note an update on Forensic Mental Health and Learning Disability Services since the opening of Rowanbank Clinic, West of Scotland Medium Secure Services in 2007. The NHS Board was also asked to endorse the proposal to locate the National Forensic Learning Disability Unit at Rowanbank Clinic.

Mrs Hawkins explained that inpatient services, in conditions of medium security, were provided at Rowanbank Clinic in the north of Glasgow with low security and close supervision learning disability services being provided at Leverndale and Dykebar Hospitals on the south-side of the city. Community and outpatient services were based at Clutha House and the Douglas Inch Centre.

She described the policy background examining the provision of mental health and social work services and accommodation for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work departments, the State Hospital, other Psychiatric services in hospital and in the community. She referred to the Scotland and Regional Analysis of Inpatient Beds – this analysis had been used to guide NHS Boards and regional planning partnerships in the development of local services. She set out expectations of the forensic service configuration that was required within Scotland to provide a full range of forensic inpatient services and the level at which these services should be commissioned.

The proposal was submitted to the Scottish Government in January 2009 and was anticipated to conclude by October 2009. In the meantime, NHSGGC was proceeding to open learning disability medium secure beds within Rowanbank Clinic as originally planned.

Rowanbank Clinic was able to accommodate twelve national learning disability beds through the use of a four bed ward originally designed for learning disability activity, along with the availability of eight beds which would be freed up by reducing the West of Scotland Health Boards' male mental illness capacity. West of Scotland Health Boards, through Regional Planning Group discussions, had confirmed their support for adjusting their male mental illness capacity to accommodate national learning disability services.

Mrs Hawkins also referred to the six bed women's medium secure ward currently operational within Rowanbank Clinic. This ward was originally planned for Greater Glasgow activity, but was currently extending access to other West of Scotland Boards. The Scottish Government was in discussion with Health Boards to confirm the number of beds required for Scotland. NHSGGC had indicated its willingness to provide access to Rowanbank Clinic on either a national or regional basis. A decision on this matter was anticipated in the near future.

Changes to the function of Rowanbank Clinic were made late on in the planning stages which resulted in the unit taking on a West of Scotland function, on an interim basis.

Mrs Hawkins explained that, following public consultation as part of the Clyde Modernising Health Strategy, this would now become a permanent arrangement. The effect on low secure beds had meant that instead of moving to Rowanbank Clinic, these beds would remain at Leverndale.

This decision meant that there was a requirement to invest in low secure services in the following ways:

- It was intended to transfer Bute Ward from Dykebar to Leverndale – forensic planning guidance and the related matrix of security standards strongly recommended that all forensic beds of a particular function should be located within the one estate.

- There was a need to provide dedicated inpatient beds for women who required low secure services, this would be achieved through a redesign of low secure beds.

- There was a need to provide low secure male mental illness beds for Clyde – current arrangements saw such patients within Intensive Psychiatric Care Units (IPCU) and admission wards; this investment was accounted for in the Clyde Mental Health Financial Plan.

In response to a question from Councillor Yates, Mrs Hawkins confirmed that an extension would be built at Leverndale Hospital to accommodate these changes. She also described the distribution of costs that would occur with Rowanbank Clinic providing a West of Scotland service – it was anticipated that there would be a saving to NHSGGC.

DECIDED:

- That the update on forensic mental health and learning disability services since the opening of Rowanbank Clinic, West of Scotland Medium Secure Services in 2007 be noted.

- That the proposal to locate the National Forensic Learning Disability Unit at Rowanbank Clinic be endorsed. **Director, Mental Health Partnership**

12. FULL BUSINESS CASE – BARRHEAD HEALTH AND SOCIAL CARE CENTRE

A report of the Director, East Renfrewshire Community Health Care Partnership (CHCP) [Board Paper No 09/07] asked the NHS Board to approve the Full Business Case for Barrhead Health and Social Care Centre for submission to the Scottish Government Health Directorates' Capital Invest Group.

Mr Eltringham explained that the current Barrhead Health Centre was opened in 1981 and had received no significant investment since. Space was severely restricted and this had hampered the development of more locally based services. Social Work teams from three surrounding properties also required relocation.

He explained that a site had been identified as suitable for a new build multi-purpose facility for Health and Social Care services. Agreements had been reached between the Scottish Government and NHSGGC that £15m (around 50%) of the funding for this development and that of the Renfrew Health and Social Work Centre would be provided by the Scottish Government, with the remaining funds being provided through NHSGGC's capital programme and a capital contribution from East Renfrewshire Council. This agreement was reached on the understanding that NHSGGC would seek to repay the Scottish Government funding from the proceeds of the future sale of property within the former Clyde area of the NHS Board's responsibilities.

Mr Eltringham noted that the Outline Business Case was approved by the Performance Review Group at its meeting on 20 March 2007. The Full Business Case identified an NHS capital expenditure requirement of £14.7m and an East Renfrewshire Council (ERC) capital expenditure contribution of £2.93m. The resultant combined capital expenditure of £17.1m indicated a slight favourable variance from the figure identified in the Outline Business Case. The expected additional revenue requirement had fallen from £880k to £876k from Outline Business Case to Full Business Case.

In response to a question, Mr Eltringham confirmed that provision for both the revenue and capital implications of the development had been made within NHSGGC's financial plans.

Ms Dhir asked about the criteria for assessment of the requirement for a new health centre such as this. Ms Renfrew explained the Board's capital planning process and how it operated to identify projects for capital development. She suggested that NHS Board Members may find it helpful to further understand this process and it was agreed that this form a topic for future discussion at a Board seminar session. **Head of Board Administration**

DECIDED:

That the Full Business Case for Barrhead Health and Social Care Centre for submission to the Scottish Government Health Directorate's Capital Investment Group be approved. **Director, East Renfrewshire CHCP**

13. UPDATE ON THE NEW SOUTH GLASGOW HOSPITALS AND LABORATORY DEVELOPMENT ON THE SOUTHERN GENERAL HOSPITAL SITE

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 09/08] asked Members to receive feedback on the outcome of the Gateway Review 2 process and an update on progress with the new Adult and Children's Hospitals and Laboratory development at the Southern General Hospital site.

Ms Byrne explained that the Gateway Review investigated the assumptions in the Outline Business Case and proposed approach for delivery of the project. The delivery strategy would include details of the sourcing options, proposed procurement route, supporting information and project methodology. The review would also check that plans for implementation were in place. The review was carried out from 27 to 29 January 2009 and the Review Team found that the project had made significant progress since the first Gateway Review in January 2008. The report set out a series of recommendations based on a traffic light system (red, amber or green status). The overall report status was amber and Ms Byrne outlined the key findings and recommendations from the review in terms of:

- Assessment of delivery approach
- Business Case and Stakeholders
- Risk Management
- Review of current phase
- Readiness for next phase – investment decision

Four green and one amber recommendation had been received. The next Gateway Review (Gateway 3 : Investment Decision) to support the approval of the Full Business Case was scheduled for September 2010.

In terms of an update on progress, Ms Byrne outlined that the overall project programme was divided into six stages over a seven year period. The Project Team and Advisers were currently working to complete Stage 1A of the project. Following the successful outcome of the Gateway 2 Review, the procurement stage had commenced. She summarised developments relating to:-

- Clinical Output Specifications – The development of the exemplar design was slightly behind the programme dates but would be accommodated within the overall timetable without impact on the tender issue date by end of 14 April 2009.

- Master Plan – The master plan had further developed and a presentation was made to Glasgow City Council with follow-up discussions arranged to manage the approval of the master plan by June 2009.

- Laboratories – The revised scope had been confirmed and the work required to develop the designs was currently out to tender.

- Energy Centre and Utilities – A decision to construct the new energy centre along with the laboratories build would be made at the end of February 2009.

- FM/Goods Delivered – The requirements had been agreed and had been incorporated into the design.

- Section 75 Agreement – The work to complete negotiation with Glasgow City Council on the Section 75 Agreement had still to be concluded. The total contribution from NHSGGC in relation to the Southern General Hospital project was £6.25M (inclusive of VAT) which was contained in the project cost plan.

DECIDED:

That the feedback on the outcome of the Gateway Review 2 process and an update on progress with the new Adult and Children's Hospitals and Laboratory development at the Southern General Hospital site be received.

Director of Acute Services Strategy Implementation and Planning

14. COMMUNITY ENGAGEMENT UPDATE ON NEW HOSPITALS

A report of the Head of Community Engagement and Transport [Board Paper No 09/09] asked Members to receive an update on community engagement activity in relation to key milestones of the Acute Services Review and, in particular, the new hospitals.

Mr McGrogan set out the preparations to engage the public on the next phases of the Hospital Modernisation Programme (Acute Services Review) – the opening of the New Stobhill and Victoria Hospitals and the early design stages of the new South Glasgow Hospitals.

He explained that, since its inception in 2004, the Community Engagement Team had met with tens of thousands of people. It had sought to listen to, involve and engage patients, carers and members of the public in a number of different ways including attendance at meetings, presentations to interested groups, drop-in sessions and outreach work.

Mr McGrogan summarised the Team's activity in respect of the new Stobhill and Victoria Hospitals and the new South Glasgow Hospitals. He highlighted the arrangements made to inform and listen to members of the public regarding these hospitals and explained that the process of engagement would be reviewed to learn lessons and inform the subsequent engagement and communication activities as the Acute Services Review was further implemented. He acknowledged the work that had taken place to ensure the design brief for the new South Glasgow Hospitals captured the high level aspirations of patients, carers and families. Work to secure employment opportunities for local communities in the construction of the new buildings had also taken place and a partnership approach to exploring and exploiting other opportunities presented by the new hospitals' investment had been established.

NOTED

15. FINAL REPORT REGARDING THE CAMBUSLANG AND RUTHERGLEN/NORTHERN CORRIDOR TRANSFER

A report of the Director, South Lanarkshire CHP, Director, North Lanarkshire CHP and Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs, NHSGG&C [Board Paper No 09/10] set out the final progress report on moving towards full implementation of the approved plans to transfer accountability, planning and governance for the localities of Cambuslang/Rutherglen and the Northern Corridor to NHS Lanarkshire.

Both NHS Boards approved the transfer, in principle, in February 2008, subject to this being undertaken in line with current statutory and regulatory directions and with an appropriate implementation process which ensured safe and legal transfer.

Following this decision, a properly constituted Project Board was established with membership drawn from both Health Boards across a range of disciplines and inclusive of key stakeholders including staff-side representatives and GPs from both localities. The Project Board provided an update on progress with the implementation in October 2008 which identified that matters were on track.
The Project Board was asked to provide a final report to both NHS Boards in February 2009 in order to give an assurance that a legal transfer could be successfully undertaken on 31 March 2009. Mr Lawrie led the NHS Board through progress to date to achieve the safe and sustainable transfer of services. He summarised this in relation to:-

- Human Resources
- Information Management and Technology
- Primary Care (Community) Services
- Primary Care (GMS) Services
- Finance
- Pharmacy and Prescribing

Two areas of work that had not moved as quickly as had been anticipated related to Estates and Facilities Management and also to the roles and responsibilities associated with the Public Health Departments in both Health Boards. Mr Lawrie commented that it had been a well organised project that had been developed with good engagement and involvement of key stakeholders. He summarised the final actions that were to be taken prior to 1 April 2009 and those future actions beyond that date.

In response to a question from Mrs Stewart, Mr Lawrie confirmed that although there were some differences in terms of both NHS Boards' staff policies – they were extremely similar and staff would work to NHS Lanarkshire's.

DECIDED:

- That the positive progress that had been made on this project over the past ten months and the assurance provided in regard to statutory requirements in readiness for the transfer of staff be noted.

- That there would be ongoing work in 2009/10 in regard to the transfer of buildings and associated services be noted.

- That there would be ongoing work in 2009/10 in regard to the transfer of Public Health functions and responsibilities to NHS Lanarkshire at a pace which was both safe and sustainable be noted.

- That the final decisions in regard to the sign-off of the various Service Level Agreements be delegated to the Chief Executive and appropriate Directors be agreed.

Director, South Lanarkshire CHP, Director, North Lanarkshire CHP and Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs

"

- That the final decisions in regard to the final sign-off of the financial transfer be delegated to the Chief Executive and appropriate Directors be agreed.

16. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 09/11] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the 7 Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

Director of Public Health

17. JOINT WORKING WITH GLASGOW CITY COUNCIL : PROGRESS REPORT

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No 09/12] asked the NHS Board to note progress of the review of joint working with Glasgow City Council.

Ms Renfrew explained that the review was covering a wider range of areas of joint work, including community planning, children's services planning, health improvement and partnership arrangements (in addition to those delivering services). The focus was not just on processes and systems for doing joint business but also on organisational arrangements and the cultures and behaviours which characterised ways of working together. The review had four elements and Ms Renfrew outlined progress on each as follows:

- Documentation of all joint arrangements with the City – this was underway.

- Systematic analysis of the models of joint working from other parts of the UK between major NHS systems and Local Authorities – this was underway.

- A structured questionnaire to gain a wide range of intelligence on the realities of joint working – this had been concluded and completed by around 80 staff.

- Workshops to enable all those involved in joint working to put forward their views and issues – the schedule of six workshops had been completed and were attended by over 100 staff from across the organisation.

The aim was to conclude the work by the end of April 2009 and create an informal opportunity to discuss the outcome with NHS Board Members at the May 2009 NHS Board seminar before finalising a report and recommendations.

Head of Board Administration

NOTED

18. GLASGOW CITY CHCPS : REPORT ON JOINT DEVELOPMENT WORK

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No 09/13] asked the NHS Board to note progress in the joint development work with Glasgow City Council and arrangements for the outcome of that work to be reported to an additional NHS Board meeting on Tuesday 3 March 2009 at 10.30 am.

Ms Renfrew provided Board Members with a report on progress and advised of the formal process to conclude this programme of work.

Progress had been made with the City Council in a number of areas which were of concern to them. A number of issues raised by the NHS, however, remained unresolved, particularly in relation to the financial arrangements and delegation of decision making which were fundamental to the agreed Scheme of Establishment for the CHCPs.

The Council Leader met the NHS Board Chair on 13 February and again restated his commitment to ensuring that the full range of issues was addressed. The NHS Board Chief Executive was continuing to work with the Council to resolve the outstanding points of concern.

Ms Renfrew proposed that on 3 March 2009 the NHS Board would be able to confirm that all matters had been positively concluded or view proposals to enable it to consider whether the CHCP Scheme of Establishment should be revised if acceptable conclusions had not been reached.

DECIDED:

That progress in the joint development work with Glasgow City Council and arrangements for the outcome of that work be reported to an additional NHS Board meeting on Tuesday 3 March 2009 at 10.30 am be noted.

Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs

19. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No 09/14] asked the NHS Board to note progress against the national targets as at the end of December 2008.

Mr Divers led the NHS Board through the report noting the NHS Board's performance. He highlighted the following:

- Outpatient Waiting Times – at the end of September 2008, the NHS Board achieved the 15 week outpatient target - six months early. The next milestone towards achieving 18 weeks referral to treatment would see no patient wait more than 12 weeks from GP referral to an outpatient appointment by the end of March 2009. The Acute Division was now working towards delivery of the 12 week waiting time target for outpatients.

At the end of December 2008, no patients were waiting over 14 weeks for an outpatient appointment.

- Inpatient/Day Case Waiting Times – at the end of September 2008, the NHS Board achieved the 15 week inpatient/day case target - six months early. The next milestone towards achieving 18 weeks referral to treatment would see no inpatient/day case wait more than 12 weeks from a decision to undertake treatment to the start of that treatment by the end of March 2009. The Acute Division had largely achieved the 12 week target three months early.

- Diagnostic Waiting Times – as a milestone towards achieving 18 weeks referral to treatment, the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy would be 6 weeks by the end of March 2009. This 6 week target was achieved at the end of December 2008 for four of these modalities.

- Cataract Targets – the maximum time from referral to completion of treatment for cataract surgery would be 18 weeks. This target was achieved in December 2007 and had been maintained since that date.

- Hip Fracture – 98% of all hip fracture patients would be operated on within 24 hours of admission to an orthopaedic unit, subject to medical fitness and during safe operating hours. The standard had been met: one patient was operated on out with the 24 hour period following admission and a detailed analysis of the circumstances surrounding this patient had been undertaken.

- Accident and Emergency Four Hour Wait – 98% of Accident and Emergency patients should be treated and discharged, admitted or transferred within four hours of arrival at the department. The NHS Board achieved this target in December 2007 and in the following eleven months. In December 2008, this dropped to 97% compliance due to levels of demand which took the form of very sharp rises in activity at different sites on different days. This position continued into January 2009 when again the NHS Board posted 97% compliance. A similar pattern had been reported across many NHS Boards in Scotland. The Emergency Care and Medical Services Directorate continued to work collaboratively with colleagues in other Directorates and with key provider agencies to ensure the NHS Board returned to 98% compliance as soon as possible.

- Cancer Waiting Times – 95% of all urgent referrals with suspected cancer should wait a maximum of 62 days from urgent referral to treatment (31 days for breast cancer). All patients referred as urgent were tracked to ensure monitoring of the progress along the patient journey. The monthly MMI returns would indicate that the NHS Board achieved the 95% target in November and December 2008.

- Chest Pain – the maximum wait from GP referral through a rapid access chest pain clinic or equivalent to cardiac intervention was 16 weeks. The NHS Board was now only responsible for rapid access chest pain services, with a target waiting time of two weeks as part of the overall 16 week patient journey. The NHS Board met the two week target throughout 2008.

- Delayed Discharge – The NHS Board was now required to maintain a performance standard of no patients waiting over six weeks for discharge. In two authorities, some areas this had not proved possible but joint work had continued where there were patients whose cases had not progressed quickly enough and where access to funding remained an issue.

- Stroke – The national QIS stroke targets were that 80% of fast track referrals to Stroke/Transient Ischaemic Attacks (TIA) clinics should be seen within 14 days and 80% of stroke patients should have a CT or MRI scan within 48 hours of admission. The Glasgow Managed Clinical Network had reviewed and changed the CT target from 48 to 24 hours as more clinically pertinent to stroke management. Fast track referrals in Glasgow met the 80% target. Progress in Clyde had shown improvement. Additional clinics had been undertaken at Inverclyde Royal and it was expected that the target would be achieved and maintained from January 2009 onwards.

Mr Carson referred to an action within the Matters Arising Rolling Action List where it had been agreed that delayed discharges would be tracked and consideration given to whether independent living allowances and packages would assist. Mr Divers agreed that this would be included in future reports. **Chief Operating Officer**

NOTED

20. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2008

A report of the Director of Finance [Board Paper No 09/15] asked the NHS Board to note the financial position for the first eight months of the financial year.

Mr Griffin reported that the NHS Board and its Operational Divisions were currently reporting an outturn in line with the revenue budget for the first eight months of the year. The NHS Board continued to forecast a revenue breakeven position for the 2008/09 year end.

Expenditure on Acute Services was running close to budget with expenditure running £0.6m under budget for the first eight months of the year. The most significant individual cost pressure continued to be expenditure on energy costs due to price increases which would result in an additional in-year cost pressure of £6m to £7m for 2008/09. The Acute Division had indicated that the in-year cost could be absorbed non-recurrently using funds released from saving schemes and in-year underspends.

Expenditure on NHS Partnerships was running slightly ahead of budget for the year to date. In particular, expenditure within the Renfrewshire CHP remained above budget. This was mainly due to additional expenditure on General Medical Services within the Clyde area which continued to run at an annual level of £1.8m above available funding.

Total expenditure for the Clyde area was running in line with budget for the year to date.

NOTED

21. NHS GG&C SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE FOR NHSGGC BOARD FEBRUARY 2009

A report of the Board Medical Director and Head of Clinical Governance [Board Paper No 09/16] asked Members to review and comment on the progress achieved by the NHS Board in implementing the Scottish Patient Safety Programme (SPSP).

Dr Cowan led the NHS Board through the report emphasising that safeguarding patients receiving care was a strategic priority for the NHS Board. As such, the Acute Service Division was currently supporting 31 pilot sites and he provided an overview of progress to date with the programme.

The SPSP approach focused on improving safety by increasing the reliability of healthcare processes in acute care. This was achieved by front line teams testing and establishing more consistent application of evidence based clinical or communication processes through four clinical work-stream packages. These packages were for Critical Care, General Ward, Peri-Operative and Medicines Management. The success of this activity was monitored through a measurement framework and supported by enhanced commitment to the priority of patient safety from organisational leadership. The programme was planned and tracked around six component objectives.

Dr Cowan explained that after the first challenging year supporting SPSP implementation, the NHS Board had made progress that had been positively evaluated at a national and local level. The Acute Service Division had further major challenges in completing the first two phases and launching the spread in the next year.

The scale of spread was unique to NHSGGC but the approach and commitment of staff was encouraging and he remained hopeful that the same level of progress would be sustained.

NOTED

22. AUDIT COMMITTEE MINUTES : 11 NOVEMBER 2008 AND 27 JANUARY 2009

The Minutes of the Audit Committee meetings held on 11 November 2008 [A(M)08/06] and 27 January 2009 [A(M) 09/01 were noted.

NOTED

23. INVOLVING PEOPLE COMMITTEE MINUTES : 1 DECEMBER 2008

The Minutes of the Involving People Committee meeting held on 1 December 2008 [IPC(M)08/06] were noted.

NOTED

24. PHARMACY PRACTICES COMMITTEE MINUTES : 1 DECEMBER 2008

The Minutes of the Pharmacy Practices Committee meeting held on 1 December 2008 [PPC(M)08/24] were noted.

NOTED

25. GREATER GLASGOW AND CLYDE CLINICAL GOVERNANCE COMMITTEE MINUTES : 2 DECEMBER 2008

The Minutes of the Greater Glasgow and Clyde Clinical Governance Committee meeting held on 2 December 2008 [CGC(M)08/6] were noted.

NOTED

ACTION BY

26. PERFORMANCE REVIEW GROUP MINUTES : 20 JANUARY 2009

The Minutes of the Performance Review Group meeting held on 20 January 2009 [PRG(M)09/01] were noted.

NOTED

27. AREA CLINICAL FORUM MINUTES : 5 FEBRUARY 2009

The Minutes of the Area Clinical Forum meeting held on 5 February 2009 [ACF(M)09/1] were noted.

NOTED

The meeting ended at 12.50pm

Greater Glasgow & Clyde NHS Board

NHS Board Meeting
24th February 2009

Board Paper No. 09/08

Report of the Director of Acute Services Strategy, Implementation and Planning

Update on the New South Glasgow Hospitals and Laboratory Development on the Southern General Hospital Site

RECOMMENDATION:

Board Members are asked to receive feedback on the outcome of the Gateway Review 2 process and an update on progress with the new Adult and Children's Hospitals and Laboratory development at the Southern General Hospital site.

1. Purpose of Paper

This paper provides feedback on the outcome of the Gateway Review 2 process and an update on the progress of the current stage of work (Stage 1A) in taking forward the New Adult and Children's Hospitals and New Laboratory Facility.

2. Gateway Review 2 : Delivery Strategy

2.1 The Gateway review investigates the assumptions in the Outline Business Case (OBC) and proposed approach for delivery of the project. The delivery strategy will include details of the sourcing options, proposed procurement route, supporting information and project methodology. The review will also check that plans for implementation are in place.

2.2 The review was carried out by a team of three reviewers led by William Harrod, one of the most experienced Gateway Reviewers in the UK.

2.3 The review was carried out on 27th to 29th January.

2.4 The Review Team found that the project has made significant progress since the first Gateway Review in January 2008. The key managers across the project all have a very detailed understanding of all areas of the project. This reflects both the quality and level of communication and the Board's approach to accountable officer responsibilities, which leads to the involvement of key players in a large number of project boards and groups. This project has taken a very robust approach to the identification of a suitable procurement route, seeking input from advisers and the marketplace. The prudent financial planning in the OBC means that the project is as well-positioned as possible to manage the uncertainties of the current economic climate. The public support of the Scottish Government in approving the OBC is expected to bring increased confidence to the market.

The Review Report (which is available upon request) sets out some potential improvements which could be made to the project structure, as well as the opportunity to carry out a more detailed description of the benefits outlined within the OBC. The project's approach to risk management has also improved with the implementation of a single risk register, and the addition of a well structured issues log.

2.5 The report sets out a series of recommendations based on a traffic light system i.e. Red, Amber or Green status:

- Red – Critical for immediate action i.e. to achieve success the project should take action immediately to address the recommendations;
- Amber – Critical before next review, i.e. the project should go forward with actions on the recommendations to be carried out before the next review;
- Green – Potential improvement, i.e. the project is on target to succeed but may benefit from uptake of the related recommendations.

2.6 The overall Report Status is **Amber.**

2.7 The findings and recommendations are as follows:

Assessment of delivery approach	No recommendations
Business Case and Stakeholders	2 recommendations: a) The project should maintain the high level of communications with internal stakeholders **(Green)** b) The project should develop a more detailed benefits management plan **(Amber)**
Risk Management	1 recommendation: The project should ensure that all members of the team understand the risk management process **(Green)**
Review of Current Phase	No recommendations
Readiness for next phase – investment decision	2 recommendations: a) The Project Board should consider a more integrated project structure **(Green)** b) The project should consider the appointment of a deputy Project Director to cope with the additional workload of future project phases and enhance the experience and capability within the GG&C Board. **(Green)**

2.8 The next Gateway Review (Gateway 3: Investment Decision) to support the approval of the Full Business Case is scheduled for September 2010.

3.0 Overall Programme

The overall project programme is divided into 6 stages over a seven year period. These are:

Stage 1A –	Employers Requirements
Stage 1B –	1st stage of Procurement – evaluate bids
Stage 2 –	2nd stage of procurement work with preferred bidder to develop design
Stage 3 –	Construction
Stage 4 –	Commission
Stage 5 –	Post Project Evaluation

4.0 Current stage - Stage 1A

The project team and advisers are currently working to complete Stage 1A of the project i.e. the Works Information (includes Employers Requirement and Exemplar Design.)

Following the successful outcome of the Gateway 2 Review, the procurement stage has commenced with the issue of OJEU Notification on Friday 6th February (published 10th February). The Pre Qualification Questionnaire (PQQ) and Memorandum of Information are available for issue to potential bidders upon request and the evaluation criteria have been agreed.

An Industry Day took place on 16th February 2009.

4.1 Clinical Output Specifications

Whilst a number of Clinical Output Specifications are still in draft or final draft status, the output to Schedules of Accommodation has been essentially frozen to permit development of the exemplar design. In the majority of cases, this carries a minimal risk as the work has been substantially completed and the likely impacts on physical area have been understood.

The revised Schedule of Accommodation (Version 7 for Adults and Version 3E for Children's) is being utilised to inform and develop the 1:500 Adjacency Layouts and 1:200 key departmental plans for:

Adults	Children's
Theatres	Theatres
Emergency Complex	Emergency Complex
Accident & Emergency	Typical Ward
Typical Ward	Schiehallion Unit
Radiology	Radiology/Cardiac Cath/Nuclear Medicine
Critical Care	Rehabilitation
Outpatients	

These drawings will crystallise the work undertaken with user groups and provide a minimum standard to which the bidders would develop their designs. It is anticipated that the resource input required from the Project Team and Clinical User Groups will be significantly reduced during the tender stage by the provision of these layouts.

The development of the exemplar design is slightly behind the programme dates, but will be accommodated within the overall timetable without impact on the tender issue date of 14 April 2009.

4.2 Master Plan

The Master Plan has further developed with the following issues requiring further development / discussion:

- New principal access route off Govan Rd
- Access/egress for Fast Link
- Site entrances and access
- Underground car parking
- A&E Car Park to the south of development site

A presentation of the revised Master Plan principles was made to Glasgow City Council and follow up discussions have been diarised to manage the approval of the Master Plan by June 2009.

The Site Investigation Works have been awarded and the works begin week commencing 9th February 2009.

4.3 Laboratories

The revised scope has been confirmed, providing facilities for:

- Mortuary (including City Mortuary)
- Biochemistry
- Haematology
- Pathology
- Genetics

The schedules of accommodation have been agreed and frozen at RIBA Stage C. As this will be an advanced work package to the main hospitals construction project, it is intended to develop the Laboratories design to RIBA Stage F/H to achieve a firm construction price at the first stage of procurement. The work required to develop the design is currently out to tender.

4.4 Energy Centre and Utilities

A decision to construct the New Energy Centre along with the Laboratories Build will be made at the end of February 2009.

Negotiations are ongoing with Utilities providers in order to mitigate the risk inherent with the provision of supplies to such a major development.

The provision of a primary sub-station is being designed into the multi storey car park proposed on the Hardgate Road boundary.

4.5 FM/Goods Deliveries

The requirements have been agreed and have been incorporated into the design on the ground floor of the laboratory buildings and these will require to be further developed by the “new” design team for the laboratories upon their appointment.

4.6 Section 75 Agreement

The work to complete negotiation with Glasgow City Council on the Section 75 Agreement has still to be concluded. The Section 75 Agreement identifies specific requirements on NHS GG&C to comply with the City Planning requirements. The main requirements are:

- Make provision for a mass transport system (Fastlink) to be incorporated into the site development plan of the Southern General Hospital. Provide a financial contribution to the Fastlink development;
- Support the enhancement of bus services for the new development by providing a financial contribution;
- Provide financial support for the provision of traffic controls on the streets adjacent to the Southern General Hospital site;
- Support enhancements to external cycling and walking routes by providing a financial contribution.

The total contribution from NHS GG&C in relation to the Southern General Hospital Project is £6.25m (inclusive of VAT) which is contained in the project cost plan.

RECOMMENDATION:

Board Members are asked to receive feedback on the outcome of the Gateway Review 2 process and an update on progress with the new Adult and Children's Hospitals and Laboratory development at the Southern General Hospital site.

Greater Glasgow & Clyde NHS Board

NHS Board Meeting

24th February 2009 **Board Paper No. 09/09**

Report of the Head of Community Engagement and Transport

Community Engagement Update on New Hospitals

Recommendation:

Board members are asked to receive an update on Community Engagement Activity in relation to key milestones of the Acute Services Review and in particular the New Hospitals.

1 Purpose of the paper

This paper sets out the preparations to engage the public on the next phases of the Hospital Modernisation Programme (Acute Services Review) – the opening of the New Stobhill and Victoria Hospitals and the early design stages of the New South Glasgow Hospital.

2 Background

Since it's inception in 2004, the Community Engagement Team has met with tens of thousands of people. It has sought to listen to, involve and engage patients, carers and members of the public in a number of different ways. These include attendance at meetings, presentations to interested groups, drop in sessions and outreach work.

Those groups who have ever expressed an interest in the ASR, or standing fora like the Community Councils, are regularly offered an update. The Community Engagement Team will also attend other events by invitation, providing an information 'drop in' session. The team also undertakes outreach every few weeks to public areas of high footfall e.g. supermarkets. Depending on the interests of the audience, subject matter can range from a geographic aspect of the ASR, types of care, impact on certain patient groups, access or specific hospitals.

3 New Stobhill and Victoria

The futures of Stobhill Hospital and the Victoria Infirmary were of great interest to certain communities. In particular, communities wished to know about the role the hospitals would play in terms of local employment, as a valued community asset, and as a provider of hospital care. Certain elements of the proposed new hospitals were of particular interest to the public – day surgery, diagnostics and the changes to unplanned care being foremost.

3.1 Stakeholder Engagement

Feedback from stakeholders – councillors, community leaders and patient groups – indicates that many of the early concerns have been addressed but there is a widespread desire for this engagement work to continue and, if feasible, to increase at certain stages in the implementation of the programme. The opening of the new Stobhill and Victoria Hospitals is such a milestone and marks an increase in the rate of service change.

3.2 Partnership Working

The Community Engagement Team meets with the Community Health and Care Partnerships/Community Health Partnerships (CHCP/CHP) Public Partnership Fora leads on a quarterly basis. Working through the offices of the Heads of Health Improvement and Planning, a programme of engagement is being progressed with all 5 Glasgow CHCPs along with East Renfrewshire CHCP, East Dunbartonshire CHP and Cambuslang & Rutherglen locality area. This work will be delivered jointly by the Community Engagement Team and the CH(C)Ps and will take place within the context of an extensive communications campaign. The work will commence in March 2009 and run until July 2009.

3.3 Community Work

The work will incorporate the delivery of outreach sessions, attendance at local community events, organisation of local briefing sessions and an update to key local community networks and fora.

- Outreach Sessions: The outreach sessions will be scheduled to provide a presence across the geographic area including high footfall areas such as shopping centres, supermarkets and local organisations' annual events being held in local community venues. To date we have 23 outreach sessions scheduled.

- Local Community Events: The local community events are regular events taking place within local areas which will attract large numbers of the community including events such as International Women's Day, International Family Day and various geographic Health and Community days. To date there are 14 community events identified between the months of March and June 2009.

- Update to key local community networks: Each area has identified the key community networks and fora that would benefit from the receiving verbal updates/ questions and answers on the forthcoming opening and the services within the new facilities. These include Black and Minority Ethnic Community networks, Public Partnership Forums, Carers Groups, Disability Groups, Mental Health Forums and Seniors' Forums. To date there have been 34 groups, networks and fora identified within the local areas to access**.**

- Community Briefing Sessions: Sessions will be organised in the locale of both Stobhill and the Victoria to offer briefings on the new hospitals, how they will function and the services within. These sessions will be focused on local stakeholders within each of the catchment areas and are proposed to take place in May and June 2009.

3.4 Review of engagement activity

In July, the engagement activity will be reviewed by the community engagement team, CH(C)P staff and public/patient stakeholders to ascertain its usefulness, learn lessons and identify improvements for future work. This type of engagement activity and structure is likely to be important in engaging with the public as further changes in acute services occur.

4 New South Glasgow Hospitals

Another major milestone in the Hospital Modernisation Programme is imminent – the issuing of a design brief for the New South Glasgow Hospitals Project. A process is currently underway to ensure that at a high level, the design brief reflects the views of patients and carers/families.

4.1 Engagement Structures – The New Children's Hospital

Over the last 18 months, a number of engagement structures have been developed to ensure continuous interaction and engagement between patients (and carers) and the New Hospitals Project Team and process. The work with young people has been of particular note. For example, members of the Youth Panel have been trained in survey methodologies and have recently undertaken research into the views of other young people on proposals regarding adolescent areas and main entrances. Using these skills, the members of the Youth Panel were asked to advise on the surveying of other young people in hospitals by the National Development Plan Team.

4.2 Engagement Structures – The New Adult Hospital

The engagement structures developed for the Adult Hospital have sought to draw upon existing structures which include the Public Partnership Forums and Managed Clinical Networks. These feed into a group called the Patients Panel which is a standing resource of patients and carers who volunteer their time to advise and assist the Acute Division on a number of topics. The South West CHCP PPF takes a lead in disseminating news, assisting in relationship building and supporting the engagement process generally.

4.3 Key Areas

As a result of this work and building upon the engagement process undertaken for the preparation of the Outline Business Case, a number of key areas/themes were identified as being of high interest to patients or carers. These are:

- Access and Wayfinding
- The External Environment
- Out-Patients
- Hospital Ward Areas and Single Rooms
- Renal Facilities
- Accident and Emergency
- Family and Carer Facilities
- Play Areas
- Adolescent Areas
- The Bereavement Pathway

4.4 IDEAS Framework

The Community Engagement Team is using the IDEAS (Inspiring Design Excellence and Achievement) Framework, developed by NHS Estates England, to support focus groups of patient and carers to generate their thoughts on the key areas. The process involves stakeholders considering the challenges different areas need to address in relation to design. It then looks at precedents (in photographic form) from recent NHS Builds to consider how these could be addressed.

4.5 Focus Groups

Fourteen Focus Groups, involving approximately 150 diverse participants are being undertaken. The outcomes are being written up, will be fed back to participants and relevant engagement structures and will inform the design brief distributed to potential bidders by the New Hospitals Project Team. The process is being observed by Architecture and Design Scotland, the Scottish Health Council and the NHSGGC Involving People Committee.

5 Engaging Partners

NHS Greater Glasgow and Clyde's investment in the New South Glasgow Hospitals Project is taking place within the context of significant regeneration activity underway or planned in the Greater Govan and South West Glasgow context. The redevelopment of the Southern General site is seen as a catalyst for wider economic and social regeneration activity, having a positive impact on the physical development of the local area and contributing substantially to the South West economy and that of the wider locality.

5.1 Socio-economic Analysis

In order to determine the potential benefits and support joint working, NHS Greater Glasgow and Clyde secured funding from partners and jointly commissioned a study to determine the potential socio-economic impacts of the proposed redevelopment of the Southern General site.

5.2 Partnership Working Group

This analysis made a number of recommendations on potential joint working opportunities. Building on the progress made to date a working group has been established to scope out these potential opportunities within the context of established and/or emerging partnership structures. This group includes representation from:

- Glasgow City Council, Development and Regeneration Services
- Scottish Enterprise
- South West CHCP
- Glasgow Housing Association
- Glasgow South West Regeneration Ltd; and
- Glasgow Community Planning Ltd
- NHS Greater Glasgow and Clyde

5.3 Priority Themes

This group has identified a number of priority themes and issues for progress. These include:

- Training and Skills
- Employment & Recruitment
- Inward Investment & Infrastructure
- Business Growth
- Marketing & Communication
- Integrated planning
- Engaging Communities

5.4 Employment and Training Benefits

Currently the Community Engagement Manager leading on this work, is working with the New South Glasgow Hospitals Project Team to focus on the employment opportunities offered by the construction of what will be one of the UK's largest hospitals. NHSGG&C will seek to incorporate such Community Benefit considerations in the procurement of the project.

5.5 On-going employment opportunities

Working in partnership with the local and city wide regeneration bodies, education and training providers, NHSGG&C will seek to sustain local employment and maximise new training and employment opportunities when the hospitals are up and running. It is scoping all such initiatives, and its own internal activities, to develop a co-ordinated approach to training/employment pathways to employment, recruitment and retention in the New Hospitals.

6 Conclusion

This paper sets out the arrangements made to inform and listen to members of the public regarding the opening of the new Stobhill and Victoria Hospital. The process of engagement will be reviewed to learn lessons and inform the subsequent engagement and communication activities as the ASR is further implemented. The paper also sets out the work that has taken place to ensure that the design brief for the New South Glasgow Hospitals captures the high level aspirations of patients, carers and families. Work to secure employment opportunities for local communities in the construction of the new buildings has also taken place and a partnership approach to exploring and exploiting other opportunities presented by the New Hospitals' investment has been established.

Board members are asked to receive an update on Community Engagement Activity in relation to key milestones of the Acute Services Review and in particular the New Hospitals.

NHSGG&C(M)09/5
Minutes: 73 - 94

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 18 August 2009 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE
Mr R Calderwood
Mr G Carson
Mr R Cleland
Councillor J Coleman (to Minute No.87)
Dr B Cowan
Ms R Crocket (to Minute No.83)
Mr P Daniels OBE
Dr L de Caestecker
Ms R Dhir MBE
Mr D Griffin
Mr P Hamilton
Councillor J Handibode (to Minute No.87)
Dr M Kapasi MBE
Mr I Lee
Councillor D MacKay
Councillor J McIlwee
Mr G McLaughlin
Mrs J Murray
Mrs R K Nijjar
Councillor I Robertson (to Minute No.87)
Mr D Sime
Mrs E Smith
Mr B Williamson
Mr K Winter
Councillor D Yates

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

Mr C Bell	..	Chair, Area Clinical Forum
Mr G Black	..	Chief Executive, Glasgow City Council (for Minute No.74)
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Ms S Gordon	..	Secretariat and Complaints Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (to Minute No.83)

ACTION BY

73. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Professor D Barlow and Councillor A Stewart.

Mr Robertson welcomed Mr C Bell as the recently appointed Chair of the Area Clinical Forum (replacing Dr D Colville). He also announced that Mr P Hamilton would be Vice Chair of the East Glasgow CHCP (as a replacement for Mrs A Coultard) and Mr B Williamson was to join the Involving People Committee.

In welcoming Mr G Black, Chief Executive, Glasgow City Council, in attendance to discuss the agenda item entitled "Joint Working with Glasgow City Council – CHCPs", Mr Robertson sought and received the NHS Board's agreement that this agenda item would be discussed first.

74. JOINT WORKING WITH GLASGOW CITY COUNCIL - CHCPs

A report of the Chief Executive [Board Paper No. 09/42] was submitted advising the NHS Board on the progress reached in relation to discussions with Glasgow City Council in relation to the Community Health Care Partnerships in Glasgow.

Mr Robertson noted that NHS Board members had been kept up to speed with developments regarding joint working with Glasgow City Council by formal and informal briefings. He commended the developments to date and explained that it was now important to crystallise progress and move to the next stage as set out in the NHS Board Paper. This was a very important issue for both NHSGGC and Glasgow City Council and he welcomed Mr Black's attendance to discuss the progress to date and to confirm the extent of the Council's commitment to the integrated and devolved CHCP model.

Mr Calderwood acknowledged that the Leader of the Council was fully committed to CHCPs with fully devolved budgets for the services and care groups for which they were responsible but the necessary financial information to deliver this commitment had not yet been delivered. The NHS Board had previously agreed that until that information was confirmed the Joint Partnership Board (JPB) could not be confidently established. However, further confident exchanges with the Council Leader had led to the conclusion that the NHS Board should move from that position in order to make progress. The paper, therefore, recommended the establishment of the shadow Joint Partnership Board.

Ms Renfrew agreed that there was the commitment within both organisations to work together under a shadow Joint Partnership Board arrangement. However, it was vital that this new arrangement did, as agreed with the Council Leader, finally conclude the financial issues which had been under discussion for several months. She suggested that to ensure the NHS Board entered the JPB with confidence and clarity on its requirements, that the recommendations be amended to confirm the requirement that the JPB agree a final version of the Scheme of Establishment which the NHS Board had already considered in draft form. It was particularly important that this included delivery of the financial information to give effect to the commitment CHCPs would hold the social work budgets for the services and care groups for which they were responsible. These proposals were endorsed by members as was the proposed November 2009 timescale for the NHS Board to consider a final scheme.

Mr Black thanked the NHS Board for the opportunity to discuss this important issue. He restated the commitment to a devolved and integrated CHCP model, in line with the similar approach the Council had taken to service reform in establishing arms-length organisations with a high degree of autonomy. Mr Black noted the work undertaken over the years by both organisations to get to this point. He described the political commitment within Glasgow City Council and explained how the governance arrangements for full devolution to CHCPs, under the auspices of the JPB, had been put in place with the joint appointment of the five CHCP Directors.

Councillor Coleman echoed this commitment both in terms of political leadership and service reform. The full devolution of budgets to the CHCPs afforded the opportunity to improve service delivery in a way that had previously not been possible and the JPB would provide the means of confirming the detail of that devolution.

Mr Williamson was reassured by both organisations' commitment and agreed that it would be essential to confirm progress in November 2009. Mr McLaughlin agreed and noted that the shadow Joint Partnership Board must positively conclude its business, particularly in relation to the revised Scheme of Establishment, given the continued enthusiasm and challenges that had been addressed so far by both organisations.

Ms Dhir referred to the wealth of experience and knowledge that existed within both organisations. This paved the way for the success of CHCPs and she hoped that staff would remain positive to see this through to fruition. Mr Black agreed and hoped there would be an element of trust regarding progress within both organisations. He outlined the outcomes the shadow Joint Partnership Board would address in confirming the budget devolution, namely, to improve service outcomes; to ensure effective management of resources and enhance greater scope for service redesign.

Ms Renfrew explained that currently all NHS resources for community health services were devolved to CHCPs. She recognised that there would be financial challenges ahead and that service redesign would be critical to improve outcomes.

In summing up, Mrs Smith recognised the huge undertaking that lay ahead. She understood that future monitoring reports would be considered by the Performance Review Group whilst the revised Scheme of Establishment (as considered by the shadow Joint Partnership Board) would be considered in November 2009 by the NHS Board.

DECIDED

- That the establishment of the shadow Joint Partnership Board and its NHS membership including the five Vice Chairs of the CHCPs, together with the Vice Chair of the NHS Board, who would act as Vice Chair of the shadow Joint Partnership Board be agreed.

- That the shadow Joint Partnership Board be required to agree a final version of the Scheme of Establishment which the NHS Board had already considered in draft form. This was to include delivery of the financial information to give effect to the commitment CHCPs would hold the social work budgets for the services and care groups for which they were responsible. **Director of Corporate Planning and Policy/Lead Director, Glasgow CHCPs**

- That this revised Scheme of Establishment be prepared and submitted to NHS Board members for approval by November 2009.

75. CHAIR'S REPORT

(i) Mr Robertson reported that he had attended four meetings in connection with the armed forces as follows:-

- On 24 June, he had attended a reception for reservists employed by NHS Greater Glasgow and Clyde to afford recognition to this staff group. He explained that a proposal was with the Cabinet Secretary for consideration to agree revised Terms and Conditions across Scotland for such staff members.

- On 13 July, Mr Robertson met with Brigadier David Allfrey (51st Scottish Brigade) and Lieutenant Colonel Gadd. At this meeting, a number of issues were discussed within the broad NHS Scotland context, but in particular, within NHS Greater Glasgow and Clyde.
- On 17 July, he had visited Combat Stress, Hollybush House, Ayr.
- On 17 August, he had visited the Erskine Army Recovery Centre in Edinburgh and had met with military personnel there.

(ii) On 30 June, Mr Robertson attended a meeting of West Dunbartonshire Council. This had been the first meeting of a regular programme to take forward matters of common interest. Similarly, he had attended a meeting of Inverclyde Council on 31 July and on 14 August the hand-over ceremony to East Dunbartonshire Council of the Kirkintilloch Integrated Care Centre had taken place.

(iii) On 21 July, Mr Robertson attended the Soil Cutting Ceremony to commence work on the new Barrhead Health and Social Care Centre. In attendance had also been Councillor D Yates and Dr H Burns (Chief Medical Officer).

(iv) On 30 July, Mr Robertson had met with Sir Muir Russell, Principal, University of Glasgow, and Mr David Newall, Secretary of Court, University of Glasgow, to take forward matters relative to the Western Infirmary Hospital site and a University presence on the new South Side Hospital Campus. On a similar theme, Mr Calderwood and Mr Robertson had met with Professor Anton Muscatelli, Principal Designate, University of Glasgow, on 17 August to take forward developments on the strategic alliance with the University of Glasgow.

NOTED

76. CHIEF EXECUTIVE'S UPDATE

(i) Mr Calderwood had visited St Margaret's Hospice and had met with Sister Rita. This meeting had been constructive and gave Mr Calderwood an opportunity to reinforce the NHS Board's position to work with the Hospice in going forward.

(ii) Mr Calderwood and senior colleagues had provided a briefing on 29 June to MSPs on the H1N1 virus. A broad range of issues had been discussed in relation not only to the handling of the Pandemic across NHS Scotland but, in particular, the response by NHS Greater Glasgow and Clyde.

(iii) On 22 July, Mr Calderwood had visited the Quarriers Epilepsy Centre at Bridge of Weir.

(iv) On 3 August, Mr Calderwood had met with Councillor Mcllwee and fellow Inverclyde Councillors including the Council Leader, Stephen McCabe, accompanied by Mr D Walker (Director, Inverclyde, CHP) to discuss the NHS Board's commitment to the Inverclyde area and to address local concerns in relation to water ingress at Inverclyde Royal Hospital.

NOTED

77. MINUTES

On the motion of Mr R Cleland seconded by Councillor D MacKay, the minutes of the NHS Board meeting held on Tuesday 23 June 2009 [NHSGG&C(M)09/4] were approved as an accurate record and signed by the Chair.

NOTED

78. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was circulated and noted.

NOTED

79. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 09/38] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme.

Dr Cowan reminded members that the Programme focused on improving safety by increasing the reliability of health care processes within Acute care. This was achieved by frontline teams testing and establishing more consistent application of clinical and/or communication processes. Success was monitored through a measurement framework and supported by a visible commitment to safety by the organisation and the achievement of an overarching set of improvement aims which currently were:-

- Mortality – 15% reduction
- Adverse events – 30% reduction
- Ventilator associated pneumonia - reduction
- Central line bloodstream infection - reduction
- Blood sugars within range (ITU/HDU) – 80% or > within range
- MRSA bloodstream infection – 50% reduction
- Crash calls – 30% reduction
- Harm from anti-coagulation – 50% reduction in ADEs
- Surgical site infections – 50% reduction (clean)

Phase 1 was launched in January 2008 and involved nine wards and by June 2008 a further 22 wards had become involved in Phase 2. Phase 3 was currently being established and a further 60 wards being prepared.

Dr Cowan provided a summary of programme implementation across NHS Greater Glasgow and Clyde. The Phase 1 frontline teams working on critical care and general ward packages were maintaining tempo that kept NHS Greater Glasgow and Clyde in line with the published Scottish Patient Safety Programme (SPSP) timeline for each workstream. He illustrated some of the reliability levels currently being observed in Phase 1 and highlighted the following:-

- There was a high level of compliance with implementing a set of preventative measures reducing Ventilators Associated Pneumonias (VAPs) in Intensive Care Units (ITUs). In the Royal Alexandra Hospital, ITU staff had been able to significantly improve compliance levels.

- There was a reduction in the rate of central line bloodstream infections that produced a period of over 200 days without such an infection in the ITU at Glasgow Royal Infirmary.
- It was known that reliable completion of Early Warning Scoring Charts was a problematic area but a team from the Royal Alexandra Hospital showed that they could generate much improved levels of reliable completion. Dr Cowan described a new communication practice to ensure all staff on duty were aware of the key safety issues. This had also generated high levels of reliability.

The full deployment of the measurement strategy around Phase 2 teams continued to be a challenge. Dr Cowan described a full breakdown of the measures available as at 13 July 2009 and explained that initial plans had not progressed as anticipated, therefore, further focus on Phase 2 teams was required to reconfirm a timeline to completion. A gap analysis was being developed to provide the necessary prediction of requirements to complete within the next 3 months.

Sustainability of measurement support had been highlighted as a programme risk so a new approach to measurement support was being developed with Phase 3 to minimise the expected challenges. This was just being rolled out so it would be a few months before Phase 3 was included in the routine update reports on progress. A number of Phase 3 teams had begun working after completing the preparatory work of identifying members and attending training. It was expected that the target of 60 new teams started before the end of 2009 would be achieved.

In terms of the Leadership Action Plan, Dr Cowan noted that it was being well maintained, however, further communication would be issued to Directors following observations of limitations in the data flow regarding walk-round actions. Walk-rounds continued to be well received by clinical staff and considered useful by Directors.

A fifth national event for the SPSP had been announced and would take place on Monday 16 and Tuesday 17 November 2009 in the SECC. Following up on feedback from staff attending the last national event, the two conferences would be targeted toward new teams as they appeared to get most from the experience.

In response to a question from Mr P Hamilton, Dr Cowan explained how valuable the walk-rounds were proving to be. This process was more direct and formal than before and an action plan was compiled that required to be completed. The whole process was monitored by the Head of Clinical Governance.

Mrs Murray asked if the improvements could be sustained. Dr Cowan responded by confirming that evidence showed (most notably from the USA) that it could. He cautioned, however, that this evidence was based on individual units and not across an area the size of NHS Greater Glasgow and Clyde. He had, however, been impressed so far with the results and seeing how challenges were being met and was hopeful that lessons learned from other countries such as Denmark and Holland would result in the sustainability of the programme. He was hopeful that the practice could be embedded within local wards.

Dr Benton asked if lessons learned and best practice were shared across all NHS Scotland Boards. Dr Cowan confirmed that this was the case and that intelligence was shared internationally via a website, regular visits and conference calls. Although this was positive and a step in the right direction, more work would be done to further share experiences but this would be addressed nationally.

NOTED

80. HEALTHCARE ASSOCIATED INFECTION – MONITORING REPORT

A report of the Medical Director [Board Paper No. 09/39] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHSGG&C. The report presented data on the performance of NHSGG&C on a range of key HAI indicators at national and individual hospital level.

Dr Cowan reminded members that the bi-monthly report outlined the position on performance in relation to:-

- S.aureus bacteraemias (HEAT Target)
- C.difficile
- Surgical Site Infections
- Hand hygiene compliance
- Monitoring of cleaning services

In summarising the report for Members, Dr Cowan reported the following:-

- If current trends were maintained, NHS Greater Glasgow and Clyde would achieve the target of a 35% reduction in S.aureus bacteraemias by 2010.
- The national report published on 8 July 2009 (January – March 2009) indicated that the annual rate of C.difficile infection in NHS Greater Glasgow and Clyde (April 08 – March 09) was 0.79 per 1000 occupied bed days. The rate for NHS Scotland was reported as 1.09 per 1000 occupied bed days for the same period.
- The Surgical Site Infections (SSI) rates in NHS Greater Glasgow and Clyde were below the national average for all procedures.
- NHS Greater Glasgow and Clyde had demonstrated a steady rise in hand hygiene compliance during the national audit periods from a 62% base line in February 2007 to achieve the 90% target in September 2008 and a current figure of 93%.
- All areas within NHSGGC scored green (>90%) in the most recent report on the national cleaning specification.

Dr Cowan led the NHS Board through the illustrations showing the number of new cases of Hospital Acquired Infection (HAI) per hospital site 2007 – 2009. In terms of Glasgow Royal Infirmary, Lightburn Hospital, Stobhill Hospital, Royal Alexandra Hospital, Inverclyde Hospital, Victoria infirmary Hospital, Southern General Hospital, Western Infirmary, Gartnavel General Hospital, Drumchapel Hospital, Blawarthill Hospital and the Vale of Leven Hospital all were within control limits in June 2009. There was one ward-based exception report within Stobhill Hospital for June 2009. Dr Cowan described work led by the antimicrobial management team in the implementation of a new antibiotic policy and supporting guidelines. These had resulted in a notable drop in C.Diff instances which was commendable.

Mr McLaughlin asked about any further targets that may be set given that the NHS Board was now meeting existing targets. Dr Cowan responded by confirming that if more challenging targets were to be set, this would be done at Scottish Government Health Directorate (SGHD) level via HEAT targets. Given that the NHS Board had met its targets in such a short space of time, however, he would be reluctant to set further challenges at the moment but would prefer that the focus be on sustaining challenges already met. He explained that there were varying degrees of success in meeting the targets across NHS Scotland Boards and, as such, the SGHD was likely to await some consistency Scotland-wide. Otherwise, it would need to enforce different targets for individual NHS Boards.

Mr Williamson congratulated the NHS Board and its leadership on the visible significant progress in infection control. Mr Cleland agreed and noted the role of the Clinical Governance Committee in monitoring the NHS Board's compliance with the targets.

NOTED

81. WINTER PLAN 2009/10 – PROGRESS REPORT

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No.09/40] asked the NHS Board to receive an update on winter planning for 2009/10 which included reference to lessons learned from 2008/09.

Ms Byrne provided a summary of the lessons learned in 2008/09. She updated on issues raised nationally and regionally and set out work underway in developing the Winter Plan for 2009/10 and the key timelines.

The 2008/09 Winter Plan for NHS Greater Glasgow and Clyde was developed on a single system basis with all partners in the delivery of key services involved. The system wide Winter Planning Group and Executive Group (with representation at senior level from across the key organisations) ensured a co-ordinated approach to the planning and delivery of services and this was being further developed in progressing the 2009/10 Winter Plan. Overall, the 2008/09 Winter Plan worked effectively and Ms Byrne led the NHS Board through some of the lessons learned that would guide winter planning for 2009/10 including communication, information sharing, the escalation plan/senior decision making rota, occupational health and public holidays. In attempting to address problems encountered in previous years, a number of new initiatives were introduced in 2008/09 which worked well and were positively welcomed by patients.

Ms Byrne confirmed that the Winter Planning Group and Executive Group had continued to meet to progress the winter planning process for 2009/10 and a national winter planning event had been held on 16 June 2009 which was very well attended by representatives from all partners across NHS Greater Glasgow and Clyde and other NHS Boards across Scotland. The point was clearly made that in planning for winter 2009/10, all NHS Boards should ensure that flu plans were aligned to the winter planning process. This would be discussed in a meeting on 7 September 2009. Concerns were raised about the four day holiday period and this had been raised separately again with the Scottish Government Health Directorate for them to review and provide guidance on service delivery during this period. It was stressed at the national event, the need to ensure there was full engagement with local authority partners, in particular Social Work, in the winter planning process. Through the CH(C)Ps, meetings were being arranged with individual local authorities as appropriate to discuss how they could become more involved in this process.

A regional event was scheduled for 24 September 2009 where NHS Boards were expected to share their draft Winter Plans with finalised Winter Plans being submitted for formal approval in October 2009. In preparation locally, a winter planning meeting would be held on 7 September 2009 to ensure all partners had in place their winter planning processes for 2009/10. It was intended that NHS Greater Glasgow and Clyde would have a prominent role at this event in sharing good practice. Following that, amendments would be made as appropriate and the Winter Plan would be considered by both the Winter Planning Group and Executive Group before submission to the NHS Board in October 2009 for formal approval.

Director of Acute Services Strategy, Implementation and Planning

In response to a question, Ms Byrne explained that, in the past, planning for winter pressures had involved preparation for and delivery of the Influenza Vaccination Scheme. Although the number of reported cases of H1N1 had dipped lately, medical experts, who had studied previous pandemics, believed the Autumn was a crucial period when an upsurge was likely.

It was, therefore, vital that the work of the NHS Greater Glasgow and Clyde Pandemic Flu Planning Group was integrally linked with the preparations being made by the Winter Planning Group.

NOTED

82. NHS GREATER GLASGOW AND CLYDE – OUTCOME OF HER MAJESTY'S INSPECTORATE OF EDUCATION (HMIe) REVIEWS - CHILD PROTECTION

A report of the Nurse Director [Board Paper No. 09/41] asked the NHS Board to note the key messages arising from Her Majesty's Inspectorate of Education Joint Child Protection Inspections for Inverclyde and Glasgow City and note the overall progress being made as a result of these.

Ms Crocket summarised the HMIe Inspection Reports for Inverclyde (which took place in February 2009) and Glasgow City (which took place in March 2009). She described the overall strengths recorded and highlighted areas for future development. In this regard, she led the NHS Board through some of the activity either underway or completed which the HMIe Inspection Reports had identified as areas of future development as follows:-

- Early involvement of health staff in child protection processes - all Child Protection Committees had an agreed tripartite discussion/initial referral discussion protocol in place or had ensured that it was being developed.
- Medical examinations of children and adolescents – paediatric medical services had been redesigned and plans were underway to roll out the Archway Service (acute sexual assault on adolescents and adults) across a wider area. Furthermore, a review of overall medical services for adolescents was in progress and a 24 hour service for all child sexual abuse cases requiring paediatric input was now in place across NHS Greater Glasgow and Clyde.
- Supervision of key staff – a model of supervision for Health Visitors and School Nurses had been agreed and training for this was currently being rolled out by Glasgow Caledonian University. A tool to assist team leaders in the supervision of child protection cases was in draft form.

Ms Crocket confirmed that the three year programme of Joint Inspections to protect children which commenced in 2005 was now complete and the NHS Board was working with all its local authorities, through their Child Protection Committees, to continue to improve child protection services.

A new model of inspection was being introduced later this year with East Dunbartonshire Council being the first local authority in the NHS Board's area to be inspected. Work was underway to understand the new inspection process and prepare for the inspection which would take place between 16 and 30 November 2009.

Both Councillors Mcllwee and Coleman welcomed the reports and, in particular, the areas identified both in Inverclyde and Glasgow City for future development. In respect of the consistent message that relevant staff must always communicate at an early stage, Ms Crocket explained that a protocol had been prepared for all staff between local authorities and the NHS in terms of the sharing of information. Processes and guidelines had been drawn up to back up practice and all local authorities had given their commitment to these. Ms Renfrew explained that the protocol would be formally launched in September 2009 and she hoped that this would enhance confidence that measures were taking place to ensure staff across relevant agencies communicated early.

Councillor MacKay found the report heartening and congratulated all staff within the NHS who had ensured that systems and joint working existed. He reflected that there was a rise in the number of children on child protection registers and this work was, therefore, paramount. Councillor Handibode endorsed these comments and suggested that the communication systems be rolled out to ensure communication existed for vulnerable adults too.

In response to a question from Mrs Nijjar, Ms Crocket confirmed that local Child Protection Committees were responsible for putting in place an action plan to address the suggested areas of development. These Committees also monitored delivery of the Plan.

Dr Kapasi asked what measures were being put in place to heighten awareness with GPs and in local accident and emergency departments. Ms Crocket responded by confirming that information about child protection had been issued twice to NHS Board staff via messages in staff pay slips. Furthermore, Child Protection Committees had been charged with looking at how to inform local communities about their role. Within A&E departments, protocols and guidelines existed and awareness had been raised significantly with the role of a Child Protection Nurse Advisor who linked in with all NHS Greater Glasgow and Clyde A&E Departments. In relation to GPs, they could access training online and each CH(C)P had training plans in place to ensure GPs were trained. This was revisited on a six monthly basis and was a key priority for CH(C)P Directors.

Mr Williamson wondered how effectiveness could be measured in relation to child protection. Ms Crocket agreed that it was difficult to have tangible outcomes in which to identify in terms of improvement in child health but she was confident that within the governance structures described earlier appropriate actions were being addressed. Referring to a comment made earlier regarding the increase of children on child protection registers, she commented that this could be, in part, due to better processes and systems working more effectively.

NOTED

83. DESIGN ACTION PLAN: UPDATE

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper 09/43] asked the NHS Board to note progress on the implementation of the Design Action Plan.

Ms Byrne led the NHS Board through the second annual progress report and explained that it outlined seven objectives against which a number of actions were identified. The NHS Greater Glasgow and Clyde Design Champion Network had continued to complete this work and supported implementation of the Design Action Plan. She summarised progress as follows:-

- Mechanisms to support effective project management, ensuring projects delivered the NHS Board's vision for design quality – 2 projects (Barrhead Health & Social Care Centre and the new maternity development on the Southern General Hospital site) were initially identified against which key concepts and processes outlined in the action plan were tested. The "test" was led by Capital Planning Managers and considered the scope, the process outline and the objectives identified in the Design Action Plan within each project.

  This approach had now been adopted within all major developments and was currently being applied to Possilpark Health Centre and planned mental health developments in Clyde.

  Since then, the guidance had been further developed as criteria for consideration when assessing tender documentation for capital projects. Ms Byrne also referred to the "Better Access to Healthcare Buildings Project" where service users with a range of individual needs and disabilities advised the NHS Board's project teams on physical design issues in relation to the new Stobhill and Victoria Hospitals.

- Stakeholder engagement – progress had been made in terms of both service user engagement and external partner engagement. An "accessibility network" had been established to support the estates and capital planning functions. This network would support ongoing systematic and proactive engagement with people with a wide range of disabilities. Furthermore, working with the Glasgow Centre for Population Health, Scottish Health Impact Assessment Network and Glasgow City Council, the new South Glasgow capital project had formally initiated a health impact assessment and equality impact assessment process to support formal engagement with external partners.

- Skills and resources to deliver the NHS Board's vision for design quality – a training needs assessment was undertaken with capital project teams, clinicians and wider NHS staff by the learning and education department in 2008 and a learning and education plan was developed to support the implementation of the NHS Greater Glasgow and Clyde Design Action Plan.

- Measured process and outcomes – the Design Action Plan outlined the need for formal review of capital projects on completion and timescales now accommodated the development of a post occupancy evaluation approach and evaluation tools which were currently being piloted within the Beatson West of Scotland Cancer Centre.

Ms Byrne concluded by confirming that the Design Action Plan continued to be developed and integrated into the range of capital projects underway across NHS Greater Glasgow and Clyde. Notably, the new South Glasgow Hospitals and Laboratory Project procurement demonstrated clear commitment to the principles and values outlined within the Design Action Plan.

Ms Dhir welcomed the progress that had been made particularly in relation to access to and around the NHS Board's premises. She was concerned, however, that information about public transport to the Board's premises was either not accessible or not available. Mr Calderwood referred to public transport leaflets that had been compiled in conjunction with Strathclyde Passenger Transport and tailored for the two new Ambulatory Care Hospitals in Stobhill and the Victoria. Investment was made for this very reason and Mr Calderwood agreed to check this with the Head of Community Engagement/Transport. **Chief Executive**

In response to a question from Mr Cleland, Ms Byrne confirmed that as part of the ongoing evaluation, the service user engagement process would be revisited to identify what lessons could be learned in terms of embedding into future processes. Mrs Grant agreed and confirmed that learning points would be identified to ensure efficiency and action for future plans.

Mr Carson commended the "Better Access to Healthcare Buildings Report" but suggested that disability groups, especially wheelchair users, be involved at the planning stages. Ms Byrne took this comment on board.

NOTED

84. NHS GREATER GLASGOW AND CLYDE – AWARD OF CONTRACT

Board Paper No. 09/44 asked the NHS Board to approve the award of the contract for taxi services for Greater Glasgow to Network Private Hire Limited.

Mr Griffin explained the background to NHS Greater Glasgow and Clyde's requirement for taxi services to transport staff, patients, records, samples and equipment between sites. He briefed the NHS Board on the competitive tendering process followed to secure the provision of taxi services within the NHS Board's area and explained that this process was overseen by a project team. The process began on 15 February 2008 with the publication of a notice in the official Journal of the EU seeking expressions of interest. Spring Radio Cars Limited trading as Network Private Hire Limited (NPH) submitted a well structured and well thought out tender response and scored highly in all criteria areas. Furthermore, the information supplied to demonstrate how NPH would deliver the service was of a high standard with all drivers servicing the NHS Board's contract having received enhanced disclosure checks.

In their response to the invitation to tender, NPH stated they had a fleet of 750 vehicles and stated a commitment to purchase a further 56 vehicles to function as facility cabs. NPH was part of the Network Group who stated on their website they were the largest private hire company in Scotland and had a number of public bodies as customers including the BBC and Glasgow City Council. As part of the competitive tendering process, references were required and in the case of NPH one of these was provided by Glasgow City Council.

Mr Griffin explained that EU Regulations required that there be a standstill period (minimum 10 calendar days) between notifying tenderers of the contract award decision and entering into a contractually binding agreement with the successful tenderer. This standstill period was intended to allow unsuccessful bidders to query or, if appropriate, challenge the award decision.

In this case, a standstill letter was issued to all tenderers on 16 January 2009. Since then a number of challenges had been made to the proposed award of a contract to NPH. Consideration of these matters had taken considerable time and, to date, prevented the award of a contract to NPH. Thorough and extensive investigations had been carried out in respect of those matters which had included obtaining legal advice and seeking the opinion of Junior and Senior Counsel. The stage had been reached where it was reasonable to conclude that the matters raised in the challenges had been resolved.

In response to a question, Mr Calderwood reported that the contract was for a 2 year period unless performance was sub-optimum in which case the contract could be terminated.

It was reported, however, that further new information had been received by NHS Board Officers immediately prior to the Board meeting and it was suggested that the recommendation receive only conditional approval from the NHS Board. Such approval being conditional upon satisfactory resolution of the matters raised in the new information.

DECIDED

That the award of the contract for taxi services for Greater Glasgow to Network Private Hire Ltd could only be granted conditional approval at this stage and would be subject to the satisfactory resolution of the matters raised in the new information provided. If the officers of the Board considered the information to be materially significant then the matter should be referred to a Performance Review Group to consider how to proceed. **Chief Executive**

85. VISION FOR THE VALE OF LEVEN HOSPITAL: UPDATE AND NEXT STEPS

A report of the Director of Acute Services Strategy, Implementation and Planning, [Board Paper No. 09/45] was submitted on the updated position on the vision for the Vale of Leven Hospital and next steps.

Ms Byrne reminded the NHS Board of the recommendations approved at the NHS Board meeting held on 24 February 2009 in respect of the Vale of Leven Hospital. These recommendations were subsequently forwarded to the Cabinet Secretary for Health and Wellbeing for her formal consideration in March 2009. She had since publically announced the outcome of her deliberations on 16 July 2009 and Ms Byrne referred to the letter addressed to the NHS Board's Chairman dated 15 July 2009 outlining her key decisions which were as follows:-

- Approve the Board's main proposals.
- Reserve final decision on the future of the Christie Ward pending a further report from NHSGGC confirming levels of admission in 12/18 months time.
- Appoint a Monitoring Group to oversee development and delivery of the service change plans.
- Require NHSGGC to carry out promotion of current and future services provided from the Vale.

The Cabinet Secretary's office had now confirmed the Monitoring Group's remit and had agreed that the most straightforward way of assembling this Group would be to reconstitute and expand the existing Helensburgh and Lomond Planning Group. This Monitoring Group would meet bimonthly and the current Planning Group Chair, Mr Bill Brackenbridge, would chair it. Ms Byrne confirmed that it would take approximately 9 months from the date of the Cabinet Secretary's approval to implement the specified service changes. An early requirement was for letters to be sent to all individuals and groups who responded to the consultation confirming the Cabinet Secretary's decision and the forthcoming actions. **Director of Acute Services Strategy, Implementation and Planning**

Councillor Robertson welcomed this and confirmed that it had been well received in the local press and with local campaigners who were pleased with the outcome. It also afforded some certainty not only to local residents but to members of staff. In respect of the Monitoring Group membership, he wondered if there was scope for Social Work representation. Ms Byrne confirmed that discussions were still ongoing to finalise Monitoring Group membership and she would make this suggestion. **Director of Acute Services Strategy, Implementation and Planning**

DECIDED

- That the Cabinet Secretary's decision on NHS Greater Glasgow and Clyde proposals for the future of the Vale of Leven Hospital be noted.
- That the progress being made to establish a Monitoring Group in line with the Cabinet Secretary's requirement be noted.
- That an outline of work and timescales required to initiate implementation of the proposals be noted.

86. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) asked the NHS Board to note progress against the national targets as at the end of June 2009.

Mrs Grant led the NHS Board through the report referring, in particular, to the following:-

- At the end of June 2009, throughout the Acute Division, no patients waited more than 12 weeks from GP referral to an outpatient appointment. Proposals were being prepared which would further reduce the stage of treatment target in advance of the 18 week referral to treatment guarantee. The next milestone would be to achieve 11 weeks, although no definite date had yet been agreed for this achievement.
- The Acute Division continued to work towards the milestone of no patient waiting over 11 weeks from the decision to undertake treatment to the start of that treatment, with the eventual aim of achieving a 9 week wait for inpatient and daycase treatment by December 2011. From April 2009, all specialities had maintained the 12 week inpatient and daycase target, with progress being made towards reducing to an 11 week position.
- The 6 week target from referral to MRI scan, CT scan, non obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy continued to be maintained. The Acute Division was currently reviewing the model required to meet the next milestone for diagnostics which was yet to be finalised.
- The target from referral to completion of treatment for cataract surgery of 18 weeks continued to be maintained.
- The target to operate on 98% of all hip fracture patients within 24 hours of admission to an orthopaedic unit, subject to medical fitness and during safe operating hours has continued to be met.
- Despite a difficult start to the year, the NHS Board had achieved 98% compliance of accident and emergency patients being treated and discharged, admitted or transferred within 4 hours of arrival at the department in 2 of the 3 months from April to June 2009. Despite increasing demand, the Directorate of Emergency Care and Medical Services remained strongly committed to maintaining a position of sustained achievement of this target.
- An internal clinical review process in respect of cancer waiting times, undertaken in conjunction with the Clinical Audit Departments, indicated that the Acute Division achieved 96.4% of all urgent referrals with suspected cancer waiting a maximum of 62 days from urgent referral to first treatment (31 days for breast cancer).
- The 2 week target for Rapid Access Chest Pain Services (as part of the overall 16 week patient journey) continued to be met.

- The standard of no patients waiting over 6 weeks for discharge had proved very challenging in recent months. There were significant staffing issues in hospital social work provided by Glasgow City that had only recently been resolved. This had delayed both allocation and assessment and, although now much improved, would have an impact for a further period. Despite additional care home places being funded in Renfrewshire, there remained patients awaiting funding being allocated for their required form of community care.

- Quality Improvement Scotland (QIS) had recently issued updated standards for the care of stroke patients in the Acute setting and the Managed Clinical Network (MCN) was currently preparing to review services against these revised standards.

Dr Benton asked if accident and emergency departments would be adversely affected with the new Junior Doctor Hours. Mrs Grant reported that this should not be the case as robust processes were in place to support revised rotas. Any breaches of the target that occurred would be scrutinised to identify if any redesign work was required.

Mr Carson commended the many positives in respect of this report and congratulated all staff involved. He suggested more textual context around the delayed discharges and would welcome further information particularly if breaches related to lack of support packages. Mrs Grant was confident that the existing issues could be resolved but agreed to provide further detail in future reports. **Chief Operating Officer (Acute Services Division)**

In response to a question from Mr Williamson regarding the 18 week referral to treatment target, Mr Calderwood confirmed that this would include all component parts of the patient journey. On a similar theme, Ms Dhir questioned the quantity and times allocated for appointments within different clinics. Mrs Grant confirmed that monitoring took place across the whole of the Acute Division to determine adherence to clinic protocols with particular regard to start and finish times for clinics.

NOTED

87. FINANCIAL MONITORING REPORT FOR THE THREE MONTH PERIOD TO 30 JUNE 2009

A report of the Director of Finance [Board Paper No.09/47] asked the NHS Board to note the financial performance for the first 3 months of the financial year.

Mr Griffin highlighted that the NHS Board was currently reporting an expenditure out-turn of £0.9M in excess of its budget for the first 3 months of the year. At this stage, the NHS Board considered that a year end break even position remained achievable.

Mr Griffin led the NHS Board through details of expenditure to date against the NHS Board's 2009/10 capital allocation and a progress report on achievement of the Board's 2009/10 cost savings target. He reminded the NHS Board that it had approved a balanced financial plan for 2009/10 which deployed £14.9M of non recurring resources in order to achieve a balanced out-turn for the year. The financial plan also assumed that £45.4M of cost savings targets would be achieved. The timing of achieving these cost savings targets would be a key factor in achieving the NHS Board's overall financial target for 2009/10.

In response to a question from Mr Lee, Mr Griffin confirmed that, as at 30 June 2009, the NHS Board had achieved savings of £10M against a year to date target of £11M. At this stage, therefore, the NHS Board was currently forecasting full achievement of its 2009/10 savings targets. He confirmed that this would be closely monitored during the remainder of the year as delivery of this savings target was crucial to achievement of the Board's revenue plan for the year.

In response to a question regarding costs associated with the H1N1 virus, Mr Griffin explained that it was difficult to be precise about exact costings as most would be associated with staff overtime. The Scottish Government Health Directorate was funding the vaccinations so there were no associated costs to local NHS Boards with this. Mr Calderwood outlined that work would be undertaken to explore financial risks going into the winter period. He anticipated that the NHS Board would continue to be responsible for the vaccination programme but not the vaccinations themselves and discussions were ongoing with the Scottish Government Health Directorate to look at the implications for local NHS Boards.

In response to a question from Mr Williamson, Mr Griffin confirmed that in relation to the Clyde deficit this would be the final financial year in respect of which this supplementary report was provided and in future a consolidated report for NHSGG&C would incorporate the Clyde activities/expenditure.

NOTED

88. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 09/48] asked that the NHS Board approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED:

That the one Medical Practitioner listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

89. INVOLVING PEOPLE COMMITTEE MINUTES: 1 JUNE 2009

The Minutes of the Involving People Committee meeting held on 1 June 2009 [IPC(M)09/3] were noted.

NOTED

90. CLINICAL GOVERNANCE COMMITTEE MINUTES: 2 JUNE 2009

The Minutes of the Clinical Governance Committee meeting held on 2 June 2009 [GGC(M)09/3] were noted.

NOTED

91. AREA CLINICAL FORUM MINUTES: 11 JUNE 2009

The Minutes of the Area Clinical Forum meeting held on 11 June 2009 [ACF(M)09/2] were noted.

NOTED

92. AUDIT COMMITTEE MINUTES: 23 JUNE 2009

The Minutes of the Audit Committee meeting held on 23 June 2009 [A(M)09/4] were noted.

NOTED

93. STAFF GOVERNANCE COMMITTEE MINUTES: 30 JUNE 2009

The Minutes of the Staff Governance Committee meeting held on 30 June 2009 [SGC(M)09/2] were noted.

NOTED

94. PHARMACY PRACTICES COMMITTEE MINUTES: 27 JULY 2009

The Minutes of the Pharmacy Practices Committee meeting held on 27 July 2009 [PPC(M) 09/05] were noted.

NOTED

The meeting ended at 11:50am

NHSGG&C(M)09/8
Minutes: 117 - 139

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 15 December 2009 at 9.30 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE	Councillor J Handibode
Mr R Calderwood	Dr M Kapasi MBE
Mr G Carson	Mr I Lee
Mr R Cleland	Councillor D MacKay
Councillor J Coleman	Councillor J McIlwee
Dr B Cowan	Mr G McLaughlin
Ms R Crocket	Mrs J Murray
Mr P Daniels OBE	Councillor I Robertson
Dr L de Caestecker	Mr D Sime
Ms R Dhir MBE	Mrs E Smith
Mr D Griffin	Mr B Williamson
Mr P Hamilton	Mr K Winter

Councillor D Yates

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

Mr C Bell	..	Chair, Area Clinical Forum
Ms S Gordon	..	Secretariat and Complaints Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs
Mr J Best	..	Director, Regional Services, Acute Services Division (to Minute No. 129)
Mr R Copland	..	Director of Health Information and Technology (to Minute No. 129)
Ms S Laughlin	..	Head of Inequalities and Health Improvement (for Minute No. 131)

ACTION BY

117. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Professor D Barlow, Mrs R K Nijjar and Councillor A Stewart.

118. CHAIR'S REPORT

(i) Mr Robertson thanked Mrs E Smith (Vice Chair) for deputising for him during his period of absence following his recent operation.

(ii) On 22 October 2009, Mr Robertson had attended a meeting of the South Glasgow Hospitals and Laboratory Project Executive Board where the Evaluation Group presented their conclusions on the tendering process. Consequently, on 26 October 2009, the Project Executive Board considered the comments from the 22 October meeting and formally endorsed the outcome and recommended that the preferred bidder be submitted to the Performance Review Group (PRG) for approval. The preferred bidder was formally approved at the PRG meeting held on 3 November 2009.

(iii) On 24 November 2009, a Board Development session for non Executive members had been held on Emotional Intelligence. This had been very well received and he encouraged all NHS Board members to attend future development sessions where possible.

(iv) From 1 April 2010, there would be two non Executive member vacancies on the NHS Board. Mr Robertson detailed the process for filling these vacancies with the Public Appointments Unit at the Scottish Government. Fifty applications had been received and a short-listing process took place on 14 December 2009 with Scottish Government Health Directorate (SGHD) colleagues. It was expected that the interviews would be held at the end of January 2010.

(v) On 4 December 2009, Mr Robertson had attended a meeting with Professor Leo Martin (Chairman, St Margaret's Hospice), at his request, to maintain an ongoing dialogue. A number of issues were raised at that meeting and a follow- up meeting was scheduled to address these on 18 December 2009.

(vi) On 7 December 2009, Mr Robertson had attended the opening ceremony of the refurbished Community Maternity Unit at Inverclyde Royal Hospital.

(vii) On 8 December 2009, Mr Robertson had met with Mr D Harley (Community Engagement Manager) and Mr G Carson to discuss the survey results from the "Better Access To Hospitals Group". This Group had undertaken a survey of the facilities provided at the two new hospitals at the Victoria and Stobhill. Many lessons had been learned and these would be fed into the planning stages for the new Southside and Children's Hospitals. Mr Robertson recorded his appreciation of the input of both Mr Carson and Mr Harley.

(viii) On 11 December 2009, Mr Robertson had met with Mr I Miller and Mr P Mullen (Chairs of the North and South Monitoring Groups respectively). This lunch had been a gesture of his appreciation on behalf of the NHS Board for their work and commitment over the six years to the Groups that had been established by the then Minister of Health.

NOTED

119. CHIEF EXECUTIVE'S UPDATE

(i) On 28 October 2009, Mr Calderwood had attended the Primary Care Strategy launch event at the Royal Concert Hall. It was attended by over 150 GPs and Clinical Team members and this had provided an excellent opportunity to debate the strategy in detail.

(ii) On 2 November 2009, Mr Calderwood had attended a General Dental Committee meeting to discuss the future of Dental Services and the Oral Health Directorate.

(iii) On 6 November 2009, Mr Calderwood had hosted (along with the Cabinet Secretary for Health and Well-being) the formal launch of the preferred bidder of the new Southside complex, namely, Brookfield Europe LP. That afternoon, Mr Calderwood had attended a meeting hosted by Renfrewshire Council to discuss Fastlink. Representatives of Strathclyde Passenger Transport (SPT) were in attendance and led a productive discussion on improving transport links to the Southside of Glasgow and Renfrewshire, including the Southern General Hospital, Braehead and Glasgow Airport. In attendance had been a range of MSPs, Councillors and officials of interested parties i.e. Glasgow Airport and Braehead Shopping Complex.

(iv) On 10 November 2009, Mr Calderwood, accompanied by Dr de Caestecker, attended a training event on Emergency Planning.

(v) On 11 November 2009, Mr Calderwood had attended as a judge on the panel of the Scottish Health Awards 2009. From over 300 nominations received, five of NHSGGC's healthcare professionals were recognised for their hard work and dedication to the Health Service. He recorded his appreciation to the winners as follows:-

- Therapists Award – Shona Flannagan, Paediatric Physiotherapist at the Vale of Leven Hospital.
- Support Worker – Margaret Nicholas, Community Health Assistant at Dumbarton Health Centre.
- Equality in Healthcare Award – Lorraine Newton, Healthcare Assistant at Springburn Health Centre.
- Cancer Care Award – Professor Tessa Holyoake, Director of the Leukaemia Research Laboratory at Gartnavel Royal Hospital.
- Women and Children's Services Award – Dr Kevin Hanretty – Consultant Obstetrician at the Queen Mother's Hospital.

(vi) On 18 November 2009, Mr Calderwood had addressed a NHS NES Conference looking at Nursing and Midwifery Services and NHS Scotland's overall manpower strategy. Many workforce challenges were debated in looking and planning to the future of the NHS in the next decade.

NOTED

120. MINUTES

On the motion of Mrs E Smith, seconded by Mr P Hamilton, the Minutes of the NHS Board meeting held on Tuesday 20 October 2009 [NHSGG&C(M)09/6] were approved as an accurate record and signed by the Chair.

NOTED

121. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was circulated and noted. Mr Robertson referred to an action from the 24 February 2009 NHS Board meeting concerning the Service Level Agreement and financial delegation sign-off for the Cambuslang/Rutherglen/Northern Corridor transfer. Ms Renfrew confirmed that she would provide an update on this at the next Performance Review Group meeting scheduled for January 2010.

Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs

(ii) Councillor MacKay referred to agenda item number 13 "Award of Contract" and proposed a motion that this item be discussed in private rather than in the public session of the NHS Board meeting. Councillor Handibode seconded this motion and a vote, by a show of hands, was conducted with the following result:-

- In favour of the motion – seven NHS Board members
- Against the motion – seventeen NHS Board members

The motion fell and Mr Robertson confirmed that the item would be discussed at the appropriate time in the public session.

NOTED

122. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 09/66] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Cowan reminded members that the Programme focused on improving safety by increasing the reliability of health care processes within Acute care. This was achieved by frontline teams testing and establishing more consistent application of clinical and/or communication processes. Success was monitored through a measurement framework and supported by a visible commitment to safety by the organisation and the achievement of an overarching set of improvement aims which currently were as follows:-

- Mortality – 15% reduction
- Adverse events – 30% reduction
- Ventilator associated pneumonia - reduction
- Central line bloodstream infection - reduction
- Blood sugars within range (ITU/HDU) – 80% or > within range
- MRSA bloodstream infection – 50% reduction
- Crash calls – 30% reduction
- Harm from anti-coagulation – 50% reduction in ADEs
- Surgical site infections – 50% reduction (clean).

Dr Cowan provided a summary of the Programme implementation across NHS Greater Glasgow and Clyde explaining that the NHS Board was currently assessed as level 2.5 by the national SPSP Team. He outlined the NHS Board's progress against SPSP target dates and the predicted trajectories for future milestones.

A full assessment was being developed against the conditions to achieve a level 3 rating, however, initial discussions suggested that a strict interpretation may mean that this may not be secured for some time due to challenges around medicines reconciliation and limited data quality associated with outcome measures. It was predicted, therefore, that NHS Greater Glasgow and Clyde would remain behind the trajectory until the final year. So far, the feedback from the SPSP national team and the Scottish Government Health Directorate (SGHD) confirmed that they remained satisfied with the NHS Board's ongoing progress and performance.

Dr Cowan led the NHS Board through key actions scheduled for completion by early 2010 as follows:-

- Engage with Directorates to establish the identity of wards to commence the Programme in 2010.
- Identify a resource model to support implementation of phase 4 of the Programme.
- Engage with Teams and Directorate Management to design a new model of collaborative learning linked to implementation group functions and leadership.
- Complete a full review of the Global Trigger Tool (GTT) process.
- Revise reporting formats, ensuring they created visibility of issues and progress for individual Directorates.
- Ensure a Local Implementation Plan for Paediatrics was developed and could be supported.

In response to a question from Mr Robertson, Dr Cowan confirmed that an update of ongoing developments in relation to SPSP would be provided at all future NHS Board meetings.

DECIDED

- That the progress achieved by NHSGGC in implementing the Scottish Patient Safety Programme be noted.

- That the need to create an endorsed SPSP aim at NHS Board level be approved.

Medical Director/ Head of Clinical Governance

123. HEALTHCARE ASSOCIATED INFECTION – MONITORING REPORT

A report of the Medical Director [Board Paper No. 09/67] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde. The report presented data on the performance of NHS Greater Glasgow and Clyde on a range of key indicators at national and individual hospital level.

Dr Cowan reminded members that the bi-monthly report outlined the position on performance in relation to:-

- S.aureus bacteraemias (HEAT Target)
- C.difficile
- Surgical Site Infections
- Hand hygiene compliance
- Monitoring of cleaning services.

In summarising the report for Members, Dr Cowan reported the following:-

- If current trends were maintained, NHS Greater Glasgow and Clyde would achieve the target of a 35% reduction in S.aureus bacteraemias by 2010.

- The national report published in September 2009 (April - June 2009) indicated that the annual rate of C.difficile infection in NHS Greater Glasgow and Clyde in the over 65s was 0.43 per 1000 acute occupied bed days. This placed NHSGGC well below the 2011 target of 0.9 per 1000 acute occupied bed days.
- The Surgical Site Infections (SSI) rates in NHS Greater Glasgow and Clyde remained below the national average for all procedures apart from hip anthroplasty.
- NHS Greater Glasgow and Clyde had demonstrated a steady rise in hand hygiene compliance during the national audit periods from a 62% baseline in February 2007 to achieve the 90% target in September 2008 and a current figure of 93%.
- All areas within NHSGGC scored green (>90%) in the most recent report on the national cleaning specification.

Dr Cowan led the NHS Board through the illustrations showing the number of new cases of Hospital Acquired Infection per hospital site 2007 – 2009. In terms of Glasgow Royal Infirmary, Lightburn Hospital, Stobhill Hospital, Royal Alexandra Hospital, Inverclyde Hospital, Victoria Infirmary, Southern General Hospital, Western Infirmary, Gartnavel General Hospital, Drumchapel Hospital, Blawarthill Hospital and the Vale of Leven Hospital, all were within control limits in October 2009. There was one ward based exception report within Inverclyde Royal Hospital for October 2009.

NOTED

124. DIRECTOR OF PUBLIC HEALTH REPORT

Dr de Caestecker presented her report on the Health of the Population of NHSGGC 2009 – 2010 entitled "An Unequal Struggle for Health". She reported that a formal launch would be held that afternoon with a full presentation of the findings and priorities for action.

Dr de Caestecker reflected that the main aim for the report was that it identify the actions and directions needed to improve health. She stressed that despite improvements in recent years, too many people in NHSGGC were still ill at too early an age. This required a collective effort to make a difference and she was calling for new ways of thinking and for a renewed conviction on the need for action to improve health. She was keen that the report be a manifesto for improving health and wellbeing over the next two years and encouraged all public and private sector organisations to step up to the challenges outlined. She reaffirmed the importance of addressing health inequalities and of supporting the most vulnerable in the population if a vibrant successful city, towns and communities were to be created.

Dr de Caestecker set out some new public health priorities for NHS Greater Glasgow and Clyde as well as reiterating priorities in her previous report for the period 2007-2009, around alcohol, obesity and early years. She discussed the NHS Board's approach to health inequalities, the need to focus on early years and the urgent need to take tough action on alcohol related problems. She encouraged different ways of thinking about the complex problems that confronted the NHS Board, for example, through the work of the Glasgow Centre for Population Health and colleagues at the University of Glasgow.

She re-emphasised the need to listen to communities and individuals about their experience of health and how they thought their health could be improved. With this in mind, much of the information came from a large interview survey of health and wellbeing and also from video interviews with a range of people as they went about their normal lives.

A recurring theme of the report was the ever present and widening contrast in health amongst different groups in the population, however, Dr de Caestecker firstly highlighted some of the improvements in health in recent years including:-

- Deaths from coronary heart disease had significantly reduced over the last ten years. This reduction was through a mixture of improved treatment and better prevention.
- Cancer survival was getting better, particularly breast cancer, childhood leukaemia, colon cancer and rectum cancer.
- The national cervical screening programme had resulted in a halving of cervical cancer rates.

Despite this progress, the health challenges remained considerable and NHS Greater Glasgow and Clyde still experienced some of the widest variations of health between the affluent and poor. Effective solutions to the problem of inequality and poor health would, however, require societal change and the involvement of many different agencies, policy makers, economists and politicians. Dr de Caestecker's joint role as Director of Public Health of NHS Greater Glasgow and Clyde and of Glasgow City Council provided valuable opportunities for public health leadership in a local authority setting.

Dr de Caestecker referred to the recent economic crisis and the potential impact of this situation on health in NHS Greater Glasgow and Clyde. She described the potential impact of the recession on unemployment, with its adverse effects on health. She emphasised that agencies within NHS Greater Glasgow and Clyde must work to mitigate the effects of the recession on health at a time when their budgets would also be constrained. Protecting budgets for activities which promoted public health and wellbeing, particularly those which could narrow the health gap may become more difficult. Dr de Caestecker believed that the public sector in NHS Greater Glasgow and Clyde should do all that it could to prevent youth unemployment and further widening of the inequalities in society even if this was at the expense of some overall economic growth. She remained an advocate for stronger national and local government roles in encouraging healthy choices to improve health.

Dr de Caestecker referred to the alcohol problem prevalent within NHS Greater Glasgow and Clyde. A major problem was the effect it had on a great number of people. She indicated that the consumption of alcohol was driven by price, availability and marketing and NHS Greater Glasgow and Clyde, like the rest of the UK, was awash with low price, heavily marketed alcohol. She strongly supported the Government's move to a minimum pricing policy and sought further restrictions on advertising and marketing. The overwhelming view of professionals and local communities was that this was a problem that was getting worse and tough action was required around licensing as well as education and effective services. Dr de Caestecker was aware, however, of the limitation for reducing consumption through price and availability alone and highlighted that Licensing Boards must listen to local communities and be willing to use the new licensing legislation as effectively as possible and not be put off tough action through fear of their decisions being challenged.

Dr de Caestecker reported that despite many improvements in child health, some aspects of childrens health were not improving. There was no doubt of the crucial, nurturing role of parents and good parenting within families and she referred to the commitment of expanding support for parents as an important step in empowering them in their crucial role. The most effective interventions to improve the lives and opportunities of vulnerable children would be delivered before they were three years old. By way of an example. Dr de Caestecker reported the consequences of vulnerability in childhood such as increased costs of health care, social care and education in childhood, and in adult life, increased costs of crime and disorder, substance misuse, worklessness and intergenerational poverty.

If this was to be addressed, more priority and attention needed to be afforded to education, child health and support for families. Dr de Caestecker sighted Triple P as an example of a positive parenting programme that had a robust evidence-base of improved child behavioural outcomes. A greater focus was needed on implementing this programme and on working with families to participate with it. This would require only modest additional resource but was dependent on leadership and commitment from all agencies and close working with families and voluntary sector groups.

In summing up, Dr de Caestecker described the priorities for action which were as relevant to all public sector agencies, private businesses and enterprises as they were to the NHS. Although agencies within NHS Greater Glasgow and Clyde were well aware of the stark statistics on health inequalities due to disadvantage, gender, age, ethnicity and disability, collectively this information and its implications had to be used in planning future service delivery.

Mr Robertson thanked Dr de Caestecker for such an insightful presentation which was supported by detailed analysis. In response to his question about the messages contained within the report being conveyed to a wider audience, Dr de Caestecker confirmed that presentations would be delivered to CH(C)Ps, local authorities and community planning groups. As work evolved to address many of the issues within the report, there would be many opportunities for different audiences to comment.

Dr Kapasi commended the report and the action points that were to be taken forward. He commented on the Scottish Government's move to minimum pricing for alcohol and suggested that any increased monies made to the exchequer as a result of such a policy should be provided to NHS organisations. Mr Sime commented that although the Scottish Government Health Directorates could introduce a minimum pricing policy, additional tax on alcohol could only be achieved on a UK basis. Dr de Caestecker reported that a modest increase in alcohol price would still save lives. In response to a question from Mr Williamson, she confirmed that, within current licensing legislation, there was the opportunity to reject an application for an alcohol outlet due to over provision and she would be advocating such a principle at future Glasgow City Licensing Forum meetings to which she had been elected the Convener.

Councillor Yates referred to the dilemma faced by local authorities in increasing access to sports and recreational facilities in times of shrinking budgets. He recognised the priority in keeping more people involved in physical activity but wondered if it was feasible to subsidise entry to sports centres. Dr de Caestecker confirmed that cost was not the main barrier that prevented people attending sports activities. Councillor MacKay referred to the likely local benefits from the Commonwealth Games and the investment commitments to this from local authorities particularly in schools where pupils were being encouraged to be more physically active. Investment was, therefore, taking place and it would be important to raise awareness and ensure accessibility to these services rather than just making them free.

Ms Dhir agreed and emphasised that it was important for all agencies to work together to improve the awareness and accessibility issues. Councillor McIlwee supported what had already been said in connection with local authority commitments to provide better sports and recreational facilities to make communities healthier.

In response to a question from Mr P Hamilton concerning the Triple P Programme, Dr de Caestecker confirmed that feedback, to date, was very positive with the majority of local authorities signed up to this programme. She confirmed that further resources were now required to undertake further elements of the programme.

Dr Benton asked about exclusion zones for burger vans and fastfood outlets located near schools. Dr de Caestecker confirmed that any action to prevent this required to be undertaken politically and the gathering of evidence about the detrimental effects of easy access to such food choices would be undertaken in the near future.

Mr Robertson commended Dr de Caestecker on behalf of all NHS Board members and the NHS Board looked forward to receiving an update on progress made in relation to the key action points at a future meeting. **Director of Public Health**

NOTED

125. NHS GREATER GLASGOW & CLYDE KEY MESSAGES FOR HEALTH FROM TWO NATIONAL INQUIRIES INTO CHILD FATALITIES: BABY P AND BRANDON LEE MUIR

A report of the Nurse Director [Board Paper No. 09/69] asked the NHS Board to note the key messages for NHS Greater Glasgow and Clyde arising from 2 national inquiries into child fatalities; Baby P and Brandon Lee Muir.

Ms Crocket summarised the messages for health in the two review reports into the care of Baby P and Brandon Lee Muir, dated May 2009 and August 2009 respectively. In looking at the lessons learned from both cases, she highlighted similar themes including the following:-

- Evaluating and the sharing of information between NHS services and relevant social work departments and other key agencies involved.
- The need for clear multi-agency ownership and leadership of child protection ensuring that all staff were clear about child protection procedures.

Ms Crocket confirmed that these reports had been examined by the NHS Greater Glasgow and Clyde Child Protection Forum. Both the Acute and Partnerships Child Protection Operational Groups were currently considering the main messages from these reports with a view to ensuring that adequate arrangements were in place in all areas identified. She confirmed that a further report would be presented to the NHS Board indicating the position in NHS Greater Glasgow and Clyde with regard to the conclusion and recommendations and any action which was required. In response to a question from Mr Robertson, Ms Crocket confirmed that such a report would be presented to the April 2010 meeting. **Nurse Director**

In responding to questions raised by Dr Kapasi, Ms Crocket agreed that it was crucial to have adequate staffing in place including paediatricians, health visitors, GPs and social workers – who were all aware of child protection arrangements. This reiterated the objective that every staff member of an organisation had responsibly for child protection issues. She agreed that this was not an area where complacency would be tolerated.

NOTED

126. PROPOSAL TO RELOCATE BOARD HEADQUARTERS AND ASSOCIATED CORPORATE FUNCTIONS

A report of the Director of Finance [Board Paper No. 09/70] asked the NHS Board to approve the preferred option to relocate the Board HQ facility and all remaining staff at Dalian House to Henderson House/West House on the Gartnavel Royal Hospital site.

Mr Griffin outlined the proposal to reprovide accommodation currently occupied at Dalian House and Tara House aimed at reducing corporate overhead costs. This proposal was capable of releasing a minimum of £840k of corporate overhead costs as an annual cost saving, commencing in 2010/11. Mr Griffin explained that this would be released by vacating accommodation currently leased at Dalian House and relocating to available accommodation on the Gartnavel Royal Hospital site while continuing with the existing lease of Tara House.

Mr Griffin led the NHS Board through the business case for this proposal explaining the key criteria used to assess four alternative options which had been identified and appraised. He summarised the costs of each of the four options and confirmed that option 3 had the shortest payback period and generated an annual cost saving, in terms of basic occupancy costs, of £840k per annum. This excluded potential additional cost savings related to the provision of other site services including catering, cleaning, maintenance, facilities and also heat/light/power costs. It was reasonable to assume that the combined costs of these services at the Gartnavel Hospitals would not exceed current expenditure levels.

In response to a question from Mr Lee, Mr Griffin confirmed that at a future point in time, planning permission would be sought for the refurbishment of further areas currently within West House which had not previously been used as office accommodation. This was necessary as these areas were currently former ward areas and any proposed change of use for accommodation within a listed building required such planning permission. He explained that this would be beneficial should the NHS Board decide, at a future date, to utilise these areas.

In response to a question from Ms Dhir, Mr Griffin confirmed that the accommodation to be occupied would incorporate Meeting Room, Conference Room and Board Room facilities and that these should be capable of use for supporting Board Appeal Hearings as required.

DECIDED

That the preferred option (option 3) to relocate the Board HQ facility and all remaining staff at Dalian House to Henderson House/West House on the Gartnavel Royal site be approved. **Director of Finance**

127. INVERCLYDE COMMUNITY HEALTH CARE PARTNERSHIP (CHCP)

Ms Renfrew reported that Inverclyde had moved to an integrated CHCP model. As such, a draft Scheme of Establishment was being finalised and would be presented to the February 2010 NHS Board meeting, with a likely formal launch date of 1 April 2010. She confirmed that the recruitment of a Director had been undertaken and an announcement was likely later that day.

Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs

Mrs Smith (Chair, Inverclyde CHP) commended this development and recorded that the CHP had gone from strength to strength since December 2006 when its first Scheme of Establishment was approved. The Partnership had excellent working relationships with the local authority and she credited Mr D Walker (Director, Inverclyde CHP) for much of this work. Councillor McIlwee echoed these comments and Mr Robertson thanked Mrs Smith for nurturing the CHP to this level.

NOTED

128. PATIENT MANAGEMENT SYSTEM (PMS) APPROVAL OF FULL BUSINESS CASE

A report of the Director of Health Information and Technology [Board Paper No. 09/71] asked the NHS Board to approve the Full Business Case for the Patient Management System for NHS Greater Glasgow and Clyde.

Mr Copland described how five Health Boards (Ayrshire & Arran, Borders, Grampian, Greater Glasgow and Clyde and Lanarkshire) had accepted a commission brief from the national eHealth Strategy Board to procure a suite of systems through a framework contract signed by NHS National Services Scotland (NSS) on behalf of NHS Scotland. The procurement was a full OJEU/competitive dialogue and the consortium was supported by Pincent Mason (legal experts in this type of OJEU) and NSS for the procurement support. The process also included two external Office for Governance and Commerce (OGC) Gateway Reviews in line with best practice.

Mr Copland reported that the procurement process identified a preferred bidder in InterSystems/TrakCare. The outcome of the consortium led procurement project was a framework contract for a single solution or suite of solutions with associated services accessible to all NHS Scotland Boards by call-off. The framework contract included Northern Ireland for the OJEU notice and partner organisations, such as hospices, if appropriate. The target date for a framework contract to be in place was January 2010.

Mr Copland confirmed that NHS Greater Glasgow and Clyde had had key representatives in all three layers of the PMS procurement project structure and this had provided confidence that the preferred solution was suitable for the NHS Board's needs. He described the system, known as the Patient Management System, and how it would be a cornerstone of the NHS Board's IT for the next decade and beyond and would be a key enabler for the implementation of the Acute Services Review.

Mr Best reported that this was a considerable undertaking and investment for NHS Greater Glasgow and Clyde. He noted the Gateway Review conclusion summary from the programme's recent Office of Government and Commerce Gateway Review. The review team considered that the PMS procurement was on track to achieve an excellent outcome both in terms of the deliverables and how they were being achieved. The team sought evidence of an exemplarily, robust procurement process that succeeded in maintaining competitive tension throughout the chosen competitive dialogue process.

Dr Kapasi asked how the richness of primary care data was going to be maintained and how data could be shared across acute and primary/community care settings. Mr Copland agreed that the focus, at the moment, was on acute provision but that the product had a good track record in other countries for being launched across mental health and community services.

He outlined a separate procurement exercise that was underway across Scotland to replace the GPASS GP system. The migration of primary care data would be part of that implementation rather than the PMS implementation. Mr Copland also outlined, in brief, the greater opportunities offered with PMS and the new GP system to share data.

In response to a question from Mr Williamson, Mr Copland outlined the differences between this system and the "Connecting for Health" system in England. Mr Copland confirmed that 75% of the population of Scotland, across 6 Health Board areas, would be using this system which was a great benefit in linking both primary and secondary care. He also referred to an intensive exercise ongoing at the moment to procure a replacement system for GPs and he anticipated both systems' implementations should run in parallel.

Mr Lee asked if clinicians had been involved in the procurement process. Mr Copland confirmed that over 100 clinicians and operational staff had been involved in the scoring, selection and presentation processes. They remained confident that this was an excellent system. Mr Best confirmed that during the roll-out phases of the PMS, staff engagement would continue as this was key in the implementation phases. Furthermore, this afforded the opportunity for the first time for a corporate set of systems.

In response to a question from Dr Benton, Mr Copland described the main components of the system in providing administration, appointments, diagnosis, the ordering of tests electronically and many clinical tools and standard templates to collect and analyse information. He accepted that a large challenge would be in re-engineering all current business processes into the new system.

Given the detailed level of interest and questions from NHS Board members, Ms Renfrew suggested a seminar session for NHS Board members to give a greater insight into the system itself. This was welcomed and would be arranged in the new year. **Head of Board Administration**

Mr Calderwood confirmed that following the NHS Board's approval, the approval of the other four Health Boards would be sought and then collectively submitted to the eHealth Programme Board at the Scottish Government Health Directorate for formal approval. This was expected to be completed by mid January 2010.

DECIDED

- That the Full Business Case for the Patient Management System for NHS Greater Glasgow and Clyde be approved. **Director of Health Information and Technology**

- That a NHS Board Seminar session be arranged in the new year to discuss this system and its links with primary care. **Head of Board Administration**

129. NHS GREATER GLASGOW AND CLYDE - AWARD OF CONTRACT

A report of the Chief Executive [Board Paper No. 09/72] asked the NHS Board to confirm the formal award of a contract for services within the Greater Glasgow area to Spring Radio Cars Ltd (trading as Network Private Hire Ltd) following the conditional approval made at the August 2009 NHS Board meeting.

Mr Calderwood reminded the NHS Board that at its meeting held on 18 August 2009, it decided to approve the award of a contract for the provision of taxi services for the Greater Glasgow area to Network Private Hire Ltd (NPH). Approval, at that time, was given on a conditional basis in the light of issues raised within information which had been provided to Board Officers by Strathclyde Police immediately prior to the commencement of the NHS Board meeting. In agreeing to conditional approval, the NHS Board charged officers with establishing whether the additional information provided was materially significant.

Mr Calderwood reported to the NHS Board that following detailed consideration of the information provided by Strathclyde Police (and after extensive consultation with Counsel), there was no viable basis for the NHS Board to set aside its responsibilities to procure within the established legal framework. He explained that not to award a contract would expose the NHS Board to an unacceptable level of risk of legal action and potential damages. For that reason, he, as the NHS Board's Accountable Officer, had a particular responsibility to recommend the formal award of the contract as the only way forward.

Councillor MacKay sought clarification around two aspects that had not been covered in the Board Paper. Firstly, he wondered if consideration had been given to Sir John Arbuthnott's Clyde Valley Review regarding the future of shared services. Secondly, he wondered what difference the legislation on booking offices would make? Mr Calderwood responded by confirming his support of the recommendations made in the Arbuthnott Review, however, clarified that they did not provide a basis to set aside this tender process. He further confirmed that the Central Legal Office had previously advised that the legislation relating to booking offices did not alter the established legal framework on which the Board was required to form its decision.

DECIDED

- That the formal award of a contract for taxi services within the Greater Glasgow area to Spring Radio Cars Ltd (trading as Network Private Hire Ltd), following the conditional approval made at the August 2009 NHS Board meeting be confirmed. **Chief Executive**

- That dissent to this decision, by the following NHS Board members, be recorded; Councillor D MacKay, Councillor J Handibode, Councillor D Yates, Councillor I Robertson and Mr P Daniels.

130. FINANCIAL MONITORING REPORT FOR THE 7 MONTH PERIOD TO 31 OCTOBER 2009

A report of the Director of Finance [Board Paper No. 09/73] asked the NHS Board to note its financial performance for the first 7 months of the financial year.

Mr Griffin reported an expenditure outturn of £1.2M in excess of budget for the first 7 months of the year, however, a year-end breakeven position remained achievable.

There remained a number of factors which could have a significant negative impact on the NHS Board's financial position during 2009/10, namely, pandemic flu, the outcome of Agenda for Change appeals and prescribing expenditure trends.

Mr Griffin explained that in setting primary care prescribing budgets, at the outset of the year, provision was made for the repayment of funding to the SGHD in respect of windfall savings anticipated from price reductions on specific drugs during 2009/10 as a consequence of the Government's Pharmaceutical Price Regulation Scheme (PPRS). The level of provision was established based on the SGHD guidance and was justified on the basis of a reduction in reimbursement rates to pharmacists on account of drug price reductions. An analysis of actual expenditure for the period to August 2009, confirmed that while the prices of a range of drugs embraced by PPRS had, in fact, reduced the prices of others drugs had increased beyond anticipated levels.

This had generated some debate between the SGHD and NHS Boards regarding what an appropriate level of repayment, related to windfall savings, should be. Until the outcome of that discussion was known, there remained the risk of an additional cost pressure of up to £2M to the NHS Board in 2009/10

NOTED

131. NHS GREATER GLASGOW AND CLYDE EQUALITY SCHEME: ANNUAL REPORT AND NEW SCHEME FOR 2010-13

A report of the Head of Inequalities and Health Improvement [Board Paper No. 09/74] asked the NHS Board to approve both the NHS Greater Glasgow and Clyde Equality Scheme 2006-09: Third Monitoring Report December 2009 and the Equality Scheme 2010-13.

Ms Laughlin explained that NHS Greater Glasgow and Clyde had an Equality Scheme and Strategic Action Plan which integrated the requirements of the different elements of the current equality legislation. The first Scheme and Action Plan were endorsed by the NHS Board in December 2006 to coincide with the requirement of the Disability Equality Duty. Public sector organisations had a requirement to produce an Annual Monitoring Report and to review and revise their Equality Schemes every three years. As such, this report had been produced to present the information that met these requirements.

Ms Laughlin led the NHS Board through the third monitoring report which considered the progress made against the strategic aims over 2009 using evidence from the review of the Equality Scheme 2006-09, together with evidence accrued from Staff Governance, Health Information and Technology and Learning and Education. She explained that the report had been produced with a number of different audiences in mind including both internal and external and the Equality and Human Rights Commission which had a mandate to ensure adherence to equality law. She summarised the conclusions of the report as follows:-

- The requirements of the equalities legislation were being progressively embedded into the fabric of NHS Greater Glasgow and Clyde in line with the general and specific duties.

- This was yet to be translated into significant measurable outcomes and the major challenge for the next Equality Scheme was to identify the means for demonstrating the impact of the equality plans and processes. A key priority was, therefore, the improved collection, analysis and use of disaggregated data in relation to shaping all elements of the patient's use of and journey through health improvement and health care services. In addition to better understanding of the patient population, it was clear that there was further work to do to ensure that NHSGGC extended its ability to recruit a workforce that was representative of the population it served.
- There were relatively few numbers of staff participating in learning and education on equality and diversity. This indicated that there remained the enduring challenge of ensuring the ongoing development of the capacity and capability of the workforce to recognise the potential for discrimination in their practice.
- There were few examples of the relationship between community engagement with equality groups and the incorporation of the issues that this generated into policy, plans, service improvements and interactions between staff and patients. NHSGGC recognised the need to demonstrate significant improvements over the next three years.

Turning to the Equality Scheme 2010-13, Ms Laughlin explained that this second Scheme built on the conclusions of the review and the findings of the three Annual Monitoring Reports. It also took into account the requirements of the forthcoming Equality Bill.

Over the course of the past three years, NHSGGC had adopted a framework for addressing inequality "10 Goals for an Inequalities Sensitive Health Service". In recognition of the interrelationship between the compliance with equalities legislation and addressing health inequalities, the action plan for the new scheme had been embedded into these ten goals. The expectation was that this would promote further mainstreaming into the implementation plans of each part of the NHSGGC system.

The NHS Board's Equality Scheme had been produced in accessible format and attractively designed to encourage a wide readership. It did, however, see its primary audience as being managers at all levels within NHSGGC as they had the accountability to deliver change and, therefore, the Equality Scheme was being launched at the 2009 corporate event for senior managers.

Mr Sime asked about the equal pay audit which was to be undertaken by the NHS Board. Mr Reid confirmed that this would be undertaken in early 2010 once the Agenda for Change reviews process had been completed.

In response to a question from Councillor Yates, Ms Laughlin confirmed that the NHS Board had a good dialogue with the Interfaith Council although recognised that certain areas were still work-in-progress.

Mr Williamson welcomed the fact that equalities legislation was being progressively embedded into the fabric of NHSGGC. He asked, however, how this would be measured, in particular obtaining the views of frontline staff on whether this was the case. Ms Laughlin was confident that the improved collection, analysis and use of disaggregated data would go someway to reassure the NHS Board that this was indeed the case.

On a similar point, she confirmed that training would be provided on a range of disability issues, also patience and empathy of staff when working with disability service users needed to be improved. This was a challenge but she was hopeful that with the help of inequalities sensitive practice, knowledge would be translated into practice.

DECIDED

- That the NHSGGC Equality Scheme 2006-09: Third Monitoring Report December 2009 be approved. **Head of Inequality and Health Improvement**
- That the NHSGGC Equality Scheme 2010-13 be approved

132. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 09/75] asked the NHS Board to note progress against the national targets as at the end of October 2009.

Mrs Grant led the NHS Board though the report and highlighted the actions being taken to deliver the waiting times and access targets.

Mr P Hamilton asked what effect the bowel cancer screening programme had had on services. Mrs Grant confirmed that prior to its implementation planning had taken place to ensure the programme could be accommodated as well as waiting time targets, particularly for cancer, being maintained. She reported that this had been the case and was confident this would continue.

Mr Williamson commended the good progress made in cancer waiting times. In response to his question concerning this, Mrs Grant confirmed that further changes were to be made to the cancer targets during 2010 / 2011 to include referrals with a suspicion of cancer (not just those deemed urgent), with full implementation by the end of 2011.

NOTED

133. QUARTERLY REPORT ON COMPLAINTS : 1 JULY – 30 SEPTEMBER 2009

A report of the Head of Board Administration, Chief Operating Officer (Acute Services) and Lead Director, CHCPs (Glasgow) [Board Paper No. 09/76] asked the NHS Board to note the Quarterly Report on Complaints in Greater Glasgow and Clyde for the period 1 July – 30 September 2009.

Mr J Hamilton reported that for this quarter, the overall NHS Greater Glasgow and Clyde complaints handling performance was 72% of complaints being responded to within 20 working days. This was above the national average which was to respond to 70% of all complaints within 20 working days. Within the quarter, and in accordance with the Ombudsman's monthly reporting procedure, five reports had been laid before the Scottish Parliament concerning NHS Greater Glasgow and Clyde cases.

A review of the Board's Complaints Handling Policy and procedures was underway and a short-life group had been established to lead on this work. It was anticipated that the group would update the policy and underpinning guidelines by early 2010. The review was taking account of comments gathered as a result of an earlier consultation process, new guidance that had emerged since the initial review and recommendations made in the Scottish Health Council sponsored review "The Craigforth Review".

Mr Hamilton referred to the Independent Advice and Support Service (IASS) Annual Review 2008/09 which had been circulated with the NHS Board papers. A national working group had been established to evaluate the IASS service and its associated data collection. In the meantime, the service had been extended for a further period until 31 March 2011.

Mrs Smith commended the efforts made by frontline staff and local complaints teams in greatly improved performance in relation to responding to complaints.

NOTED

134. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 : LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 09/77] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED

That the 5 Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

135. CLINICAL GOVERNANCE COMMITTEE MINUTES : 6 OCTOBER 2009

The Minutes of the Clinical Governance Committee meeting held on 6 October 2009 [GGC(M)09/5] were noted.

NOTED

136. AREA CLINICAL FORUM MINUTES : 8 OCTOBER 2009

The Minutes of the Area Clinical Forum meeting held on 8 October 2009 [ACF(M)09/4] were noted.

NOTED

137. INVOLVING PEOPLE COMMITTEE MINUTES : 12 OCTOBER 2009

The Minutes of the Involving People Committee meeting held on 12 October 2009 [IPC(M)09/04] were noted.

NOTED

138. PHARMACY PRACTICES COMMITTEE MINUTES : 26 OCTOBER 2009 AND 4 NOVEMBER 2009

The Minutes of the Pharmacy Practices Committee meetings held on 26 October 2009 and 4 November 2009 [PPC(M)2009/07] and [PPC(M) 2009/08] were noted.

NOTED

139. PERFORMANCE REVIEW GROUP MINUTES : 3 NOVEMBER 2009

The Minutes of the Performance Review Group meeting held on 3 November 2009 [PRG(M)09/06] were noted.

NOTED

The meeting ended at 12:10 pm

NHSGG&C(M)10/05
Minutes: 87 – 110

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 26 October 2010 at 9.30 am**

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Professor D Barlow
Dr C Benton MBE
Mr R Calderwood
Mr G Carson
Mr R Cleland
Councillor J Coleman (to Minute No. 99)
Dr B N Cowan
Ms R Crocket
Mr P Daniels OBE
Dr L de Caestecker
Ms R Dhir MBE
Mr I Fraser
Mr D Griffin
Mr P Hamilton (to Minute No. 98)
Councillor J Handibode
Dr M Kapasi MBE
Councillor D MacKay
Councillor R McColl
Councillor J McIlwee (to Minute No. 98)
Mrs J Murray
Mrs R K Nijjar
Mr D Sime
Mrs E Smith
Councillor A Stewart
Mr B Williamson
Mr K Winter

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

Ms S Gordon	..	Secretariat Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mrs A Hawkins	..	Director of Mental Health Partnership (for Minute No. 97)
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs (for Minute No. 96)
Mr D Ross	..	Director, Currie and Brown UK Ltd (for Minute No. 94)
Mr A Seabourne	..	Project Director, New South Glasgow Hospitals (for Minute No. 94)

ACTION BY

87. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr C Bell, Mr I Lee, Rev Dr N Shanks and Councillor D Yates.

Mr Robertson welcomed the NHS Board members and attendees to the first Board meeting held in the new Corporate Headquarters, J B Russell House.

88. CHAIR'S REPORT

(i) On 19 August 2010, Mr Robertson had attended the opening, by the Cabinet Secretary for Health and Wellbeing, of the new Renfrew Health and Social Care Centre.

This was a very successful project which brought new life to Renfrew as the new Centre co-located the provision of GP services, social work and learning disability services. Feedback from staff and users of the Centre, to date, had been exceptionally positive.

(ii) On 6 September 2010, Mr Robertson had hosted a visit from the Chair and Chief Executive of South Staffordshire and Shropshire Health Care NHS Foundation Trust with whom, in Partnership, NHS Greater Glasgow and Clyde provided Mental Health Services to the Armed Forces. They had been most impressed to see the facilities and services provided by Gartnavel Royal Hospital.

(iii) On 15 September 2010, Mr Robertson and Mr Griffin had attended a meeting of Kirkintilloch's Initiative Partnership Board. He commended the work of the Kirkintilloch Health and Social Care Centre and confirmed that the NHS Board and Partnership Board's joint working had now delivered on two major projects; the new Leisure Centre and the Health and Social Care Centre with the third major project, the Kirkintilloch Link Road due to complete in early November.

(iv) Mr Robertson had attended a reception for reservists in NHS Greater Glasgow and Clyde's employment many of whom had just spent up to three months being responsible for medical and surgical services at Fort Bastion. He also alluded to the picture displayed at the reception area of J B Russell House which showed a recovery unit in Afghanistan and which had been presented to the NHS in appreciation of our support for our Reservists.

(v) On 8 October 2010, Mr Robertson had met with Mr K Hill, the newly appointed Director of Women and Children's Services. From this meeting, he had got a good sense of anticipation of the move of the Children's Hospital from its current site at Yorkihill to the South side.

(vi) On 12 October 2010, Mr Robertson had visited Mr David Allan at the Queen Elizabeth National Spinal Injuries Unit for Scotland. He commended this highly impressive specialist unit.

(vii) On 15 October 2010, Mr Robertson had visited Bodyworks at Parkhead Forge Shopping Centre. This was a peripatetic exhibition which included the simulation of many body parts. It had been provided by Glasgow City of Science and its huge throughput was in recognition of the excellent and informative display.

(viii) On 20 October 2010, Mr Robertson, along with other Non Executive members of the Board, had viewed a mock up of the en suite bedrooms proposed for the new south side hospitals.

(ix) On 22 October 2010, Mr Robertson had met with the Chair of St Margaret's Hospice. This meeting would be followed up with a letter from Mr Robertson re-emphasising the need to have a Service Level Agreement (SLA) with the Hospice as existed between the NHS Board and other Hospice providers and identifying future options for the continuing care beds currently located in St Margaret's.

NOTED

89. CHIEF EXECUTIVE'S UPDATE

(i) On 1 October 2010, Mr Calderwood had attended a Scottish Government Forum to discuss, with other agencies and Public Sector bodies, the current Public Sector climate and how each could work more collaboratively. From this meeting Statements of Intent would be drawn up and he would keep the NHS Board notified of further developments.

(ii) On 4 October 2010, Mr Calderwood and the Chairman had conducted interviews for the post of CHP Director for the new Glasgow City CHP. He reported that Anne Hawkins (Director, Mental Health Partnership) had been appointed. The transition date to the new structures for Health and Social Care Services was being finalised with the Glasgow City Council, at which time Mrs Hawkins and her new team would take up their responsibilities.

(iii) On 6 October 2010, Mr Calderwood took part in a leadership debate at the Institute of Health Service Management Conference which explored how leaders dealt with competing service objectives alongside fiscal demands in delivering service provision.

NOTED

90. MINUTES

On the motion of Mr I Fraser, seconded by Dr M Kapasi, the Minutes of the NHS Board meeting held on Tuesday 17 August 2010 [NHSGG&C(M)10/04] were approved as an accurate record and signed by the Chair.

NOTED

91. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was circulated and noted.

Mr Robertson reported that some later agenda items would be re-ordered to facilitate other pressing priorities of presenters.

NOTED

92. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 10/42] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Cowan reminded members of the overall NHS Greater Glasgow and Clyde aim to ensure the care provided to every patient was safe and reliable. The Scottish Patient Safety Programme's (SPSP) aim was to achieve full implementation of the core programme in the Acute Services Division by the end of 2012.

Dr Cowan described the core programme as including improved staff capability in all wards and the creation of reliable processes for every relevant element in every ward. He confirmed that the NHS Board was also developing SPSP-style improvement programmes in Paediatrics and Mental Health Services in 2010 then in Primary Care and Obstetrics in 2011.

Dr Cowan led the NHS Board through the update report and noted, in particular, four success areas:-

- Ward 43 (Glasgow Royal Infirmary) had become the first Acute receiving ward in NHS Greater Glasgow and Clyde to achieve six consecutive data points demonstrating high reliability in medicine reconciliation at admission. This had been expected given the major redesign work the team had completed and was significant given that it was over the period of the new junior doctor intake in August 2010. Another major factor to be recognised was that the Ward created a prescriber-led reconciliation model rather than a pharmacy-led model.
- Areas not previously showing the required level of high reliability had now all been successful and the NHS Board would now progress to the next point on the national SPSP assessment trajectory.
- The start-up programme had been accelerated and it was now expected that all adult ward and theatre teams would be working within the programme by Easter 2011. This was six months earlier than originally planned.
- The NHS Board had been asked by the national team to support improved engagement of medical staff leadership. The national target was to identify 100 doctors over a 100 day period across Scotland. As a result of NHS Greater Glasgow and Clyde's local efforts, 75 doctors had been identified who had taken on key roles in the programme over recent months.

Professor Barlow confirmed that the NHS Board's Clinical Governance Committee also studied SPSP data at each of its meetings and had been most impressed with local activities.

In response to a question from Mrs Murray concerning the "100 doctors in 100 days" programme, Dr Cowan reported that this development in the programme was introduced in response to reports of a lack of medical engagement. The national team, therefore, introduced an aim to recruit 100 new doctors to the programme work within 100 days. All Boards were asked to address this issue by introducing medical staff to the programme and ensuring that they became involved in pushing forward the work.

Dr Kapasi commended the report and, in thanking Dr Cowan for his leadership in taking it forward, hoped the excellent momentum continued.

NOTED

93. HEALTHCARE ASSOCIATED INFECTION – REPORTING TEMPLATE (HAIRT)

A report of the Medical Director [Board Paper No. 10/43] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde. Dr Cowan confirmed that this was the first report in the revised template style as specified by the Scottish Government. As requested by the NHS Board, however, the previously reported Statistical Process Charts were attached as an appendix.

Dr Cowan highlighted four key Healthcare Associated Infection headlines for October 2010 as follows:-

- In 2007, the Scottish Government Health Directorate (SGHD) issued HEAT Targets in relation to S.aureus bacteraemias (SABs) which required NHS Greater Glasgow and Clyde to reduce SABs by at least 35% by April 2010. Dr Cowan was pleased to report that this target had been achieved.

  In 2010, this target was extended by an additional 15% and NHS Greater Glasgow and Clyde's progress would be included in future Board reports.

- The national report published in July 2010 showed a further reduction in the rate of C.difficile infection within NHS Greater Glasgow and Clyde and clearly placed the NHS Board below the national mean (0.47 per 1000 Occupied Bed Days (OBDs) over 65s) and also below the 0.6 per 1000 OBD HEAT Target for 2011. The rate for the most recent quarter reported (January-March 2010) was 0.34 per 1000 OBDs. This was a reduction from the previous quarter from 0.36 to 0.34 per 1000 OBDs.

- The Surgical Site Infections (SSI) rates in NHS Greater Glasgow and Clyde, (for the first quarter of 2010), remained below the national average for all categories apart from reduction of long bone fracture and repair of neck femur procedures.

- Cleanliness Champions Programme – the Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHS Greater Glasgow and Clyde had supported over 2000 members of staff who were now registered Cleanliness Champions.

Dr Cowan led the NHS Board through the various "report cards" that provided information for each Acute Hospital and key community Hospitals. In addition, there was a single report card which covered all community hospitals (which did not have individual cards) and a report which covered infections identified as having been contracted from outwith hospital. He explained that the information in the report cards was provisional local data and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports were official statistics which underwent rigorous validation which meant that final national figures may differ from those reported to the NHS Board.

Professor Barlow welcomed clarification on the differing local/national figures. This was particularly important as it had to be hoped that, as levels got lower, there was not an over-reaction to any sudden peak. Such peaks may arise when the figures were so low and simply one instance then occurred. Given this, it was also important to look at global trends.

With regard to "out of hospital infections", Dr Cowan clarified that these accounted for people who presented to hospital with infections. All patients were now routinely screened for MRSA and those patients who presented with symptoms of diarrhoea where also screened for C.diff. In response to a question from Mrs Nijjar, Dr Cowan highlighted some measures taking place to improve out of hospital infection rates including work ongoing with GPs and prescribing advisors to ensure the correct prescribing of the correct antibiotics. This should go some way to reduce this infection rate.

NOTED

94. FULL BUSINESS CASE - NEW SOUTH GLASGOW ADULT AND CHILDREN'S HOSPITALS

A report of the Project Director, New South Glasgow Hospitals [Board Paper No. 10/44] asked the NHS Board to approve the Full Business Case (FBC) for the new South Glasgow Hospitals. Thereafter, it was planned to submit the FBC to the Capital Investment Group (CIG) for consideration at their meeting of 9 November 2010.
Mr Seabourne delivered a detailed presentation describing the strategic context of the project and the actions undertaken since Outline Business Case approval. He outlined the scope of the new hospitals, the Stage 2 design work undertaken, expected benefits of the project, governance and contractual arrangements, risk management, financial appraisal, status of planning permission, economic benefits to the local community and the outcome of the recent Gateway Review. He concluded by displaying various illustrations and photographs of how the new South Glasgow Hospitals would look following completion.

In terms of a timetable for the project, Mr Seabourne explained that, if the FBC was approved and everything else went to plan then it was hoped that construction of the Adult and Children's Hospitals should be completed in January 2015. This would see the new South Glasgow hospitals achieving the gold standard triple co-location of adult, children's and maternity services.

Mr Seabourne summarised the scope of the Adult and Children's Hospitals as follows:-

- New Adult Hospital – would be a 1,109 bedded adult new build acute hospital providing A&E services and acute specialist in-patient care, a small volume of medical day cases and out-patient clinics serving the local (South West Glasgow) population. No day surgery would be undertaken as this would be provided at the new Victoria Hospital.

- New Children's Hospital – this proposed a new 256 bedded children's hospital and would provide A&E services and a comprehensive range of in-patient and day case specialist medical and surgical paediatric services on a local, regional and national basis. The new development would also have out-patient facilities. The NHS Board's strategy was that all Glasgow's children's services (up to the age of 16 and up to 18 year where appropriate) would be provided at the new children's hospital.

The Laboratory Project remained on programme to be completed by mid March 2012 and the procurement programme was making good progress, with the work packages tendered prices coming in within allocated budgets.

Mr Ross of Currie and Brown UK Ltd reported that the project had demonstrated and followed good management processes and had robust risk management governance structures in place. Risk management had been, and remained, a primary focus in the management of the project. In developing all aspects of planning the new facilities, Mr Ross confirmed that the project team and advisors had proactively managed potential risks by early identification and action to ensure maximum reduction and mitigation of risk. This approach had been enacted at all key stages of the project including pre-procurement, during procurement and post procurement and had included actions such as market sounding, consultation with key organisations, community engagement, robust control of any limited specification changes and ensuring the site to be handed over to the contractor was clear with known ground conditions.

Mr Ross summarised the contract between NHS Greater Glasgow and Clyde and Brookfield Construction Limited (BCL) and confirmed that there was collaborative working between both parties in taking the project forward.

Mr Griffin outlined the financial appraisal of the project explaining that, as part of finalising the FBC, an exercise was undertaken to recalculate both the capital and revenue consequences of the new South Glasgow Adult and Children's Hospitals to ensure that the preferred solution continued to be affordable in both capital and revenue terms. He explained that the original contract value, agreed with the preferred bidder in December 2009 for the construction of the hospitals, was confirmed as being within the overall affordability envelope. Since contract award, strict change control procedures had ensured minimal change to this contract value. The aggregate of the contract value at October 2010, and all other associated costs including equipment, fees, other non works costs, VAT (at the 20% rate applicable from January 2011) and a reasonable provision for quantified risk (agreed in conjunction with professional advisors), remained within the overall capital budget and the affordability envelope for the project. Furthermore, the impact the project would have on the NHS Board's revenue position had also been revisited during the preparation of the FBC. Mr Griffin noted that the updated cost estimates confirmed that by proceeding with the project, the NHS Board was forecasting the achievement of a net revenue saving of £18M. This saving arose partly due to a reduction in capital charges to be incurred on the new hospitals and significantly through service redesign.

Dr Cowan congratulated Mr Seabourne and his team for the comprehensive nature of the FBC. He fully supported the project and recognised the huge benefits to Glasgow, patients and clinicians. Better accommodation would be provided for patients and clinicians were looking forward to this new resource which also achieved significant efficiencies.

Ms Crocket echoed Dr Cowan's comments and paid tribute to the huge engagement undertaken by the project team especially with clinical staff and members of the public. Such engagement had been worthwhile and hugely significant in reaching this stage. Mrs Grant agreed and, despite many challenges along the way, reaffirmed the enthusiasm from staff to meet the aspirations of the project.

Mr Williamson recorded the support from clinicians and professionals not only within the NHS Greater Glasgow and Clyde area but outwith. This project would see a new Centre of Excellence in Glasgow which was a very exciting development for medicine and surgery.

Mr Winter had visited the site and met with the project team and the contractor. In his view, the project had been excellently managed to date with the new buildings being designed to address environmental issues in energy consumption and carbon footprint. This provided a good working environment which would enhance staff morale, recruitment and retention. The new builds would also allow innovative solutions for materials management and logistics.

As Chair of the Audit Committee, Mrs Smith paid tribute to this project and the fact that it was forecast to be delivered on budget and on time. She congratulated all staff involved in reaching the FBC stage and had no hesitation in providing the project with her support.

In response to a question from Dr Kapasi, Mr Seabourne described the new automated dispensing facility that would be available on the new site.

Councillor MacKay welcomed this public sector procurement model and the form of contract agreed. He asked where Fast-link featured in terms of ease of public access. Mr Seabourne responded by confirming that this formed part of the section 75 agreement with Glasgow City Council and negotiations were ongoing to establish the necessary transport routes and infrastructures.

Professor Barlow referred to the full size mock-ups of an adult en suite bedroom, children's bedroom and en suite, the staff touch down and a working space mock up of a critical care space that had been built to assist users in developing the individual room layouts. This had proved to be extremely helpful in progressing the design and aided understanding of what the final layout would look like. He asked about any likelihood of the Scottish Government changing its policy on capital charging before anticipated completion of the FBC. Mr Griffin confirmed that this change had been made by the Scottish Government due to the bank's base rate being continually reduced. It could happen again if policy changed, however, Mr Calderwood reported that it was 18 years ago that the Treasury last made a change to capital charging so a future regular change was unlikely.

In response to a question from Mrs Dhir, Mr Griffin confirmed that a number of key contractual risks had already been mitigated through work undertaken over the past months and this included the rise in VAT to 20% from January 2011. This had been accounted for within the current budget.

In response to various questions from Mr Carson, it was confirmed that total bed provision at the new hospitals (1365 beds) was a reduction in respect of the existing model but that, due to further efficiencies and reduction in patient's length of stay, a smaller bed base would still allow the NHS Board to meet the Government's HEAT targets. Mr Seabourne confirmed that the community engagement team had actively worked with Groups with disabilities to ensure their input to the layout and design of the hospitals. Similarly, there would be disabled parking bays (some within 50 metres of the new buildings) within the new campus.

In response to a question from Mr P Daniels regarding the Gateway 3 report, Mr Seabourne confirmed that this was very positive and two actions had been highlighted for completion before the next Gateway Review. These were to add some indirect risks (such as political risks) to the risk register and continue to develop the benefits management plan to define targets and gather baseline data.

Dr Benton asked what the likelihood was of the capital receipts not materialising. Mr Griffin responded by confirming that there was a risk associated with this particularly given that the property market had been very difficult to predict. Some of the NHS Board's surplus sites, however, were likely to be very attractive for disposal and would hopefully be marketable when the time came. In terms of the Scottish Government election scheduled for May 2011, Mr Calderwood confirmed that this project would form part of the current Government's decision making and, therefore, any change of Government would not have an impact.

In summarising, Mr Calderwood emphasised that NHS Greater Glasgow (and latterly NHS Greater Glasgow and Clyde) had spent many years developing an acute services strategy for the City. Despite many challenges, the programme saw investment of £1.5 billion when completed. The FBC had been a significant piece of work and he commended Mr Seabourne and his team for taking this forward.

DECIDED

That the Full Business Case for the new South Glasgow Hospitals be unanimously supported and approved. **Project Director**

95. HEALTH IMPACT ASSESSMENT (HIA) OF THE CITY OF GLASGOW LICENSING BOARD, LICENSING POLICY STATEMENT

A report of the Director of Public Health [Board Paper 10/45] asked the NHS Board to note the Health Impact Assessment (HIA) of Glasgow City Council's Licensing Policy and support its recommendations.

Dr de Caestecker described the unenviable record in relation to alcohol misuse in NHS Greater Glasgow and Clyde. Local data showed that the prevalence of alcohol misuse in the Board's area was worse than the rest of Scotland. Glasgow Health Commission 2009 recommended that the City make use of its powers, under the licensing legislation, to tackle some of the issues around alcohol misuse in the City. Alcohol licensing policies were reviewed on a three yearly basis and the Glasgow City Licensing Board must review its Licensing Policy by November 2010. The opportunity was presented, therefore, in the last year to influence the development of its new policy.

At the end of 2009, with the approval of Glasgow City Licensing Forum, a multi agency group was established to carry out a Health Impact Assessment of Glasgow City's Alcohol Licensing Policy. Dr de Caestecker described how this Health Impact Assessment was undertaken and explained that it contained 64 recommendations. Most of these related to the Licensing Board, though there were some directed at the local council, Strathclyde Police and Scottish Government. In general, the recommendations related to four main areas as follows:-

- Improving accessibility of the licensed trade, local communities and individual members of the Public to the licensing policy process as originally intended by national legislation.

- Developing a tool for use by the Licensing Board in assessing over provision of licensed premises.

- Providing guidance to the Licensing Board on the relationship between Public Health and the Licensing Policy.

- Encouraging enforcement of existing laws to protect our communities.

Dr de Caestecker explained that, while adoption of these recommendations would not transform the poor alcohol related health within Glasgow City, they would help to ensure that communities and agencies could use the Licensing Policy to limit, to a degree, the harm due to alcohol misuse. Adoption of these recommendations would also help to ensure that alcohol consumption may be enjoyed by those who use it sensibly and was likely to result in a more positive relationship with alcohol by our local population.

In response to a question from Councillor McColl, Dr de Caestecker confirmed that data generated from Strathclyde Police and NHS Greater Glasgow and Clyde would be provided to Glasgow City Licensing Board to inform their decision making process. Mr Williamson welcomed this particularly as the data provided would include alcohol associated hospital admission rates, alcohol associated crime rates and alcohol associated death rates. Dr de Caestecker agreed that the data would be useful to the Licensing Board and it was important to present it in an easy to understand way to maximise its use.

Councillor MacKay referred to cross party support for the minimum pricing of alcohol as well as the social responsibility of its misuse. He was anxious that the application of the Licensing Policy did not affect those responsible license holders. Dr de Caestecker responded by confirming that the NHS Board did lobby the Scottish Government in terms of overall social responsibility and agreed that Glasgow City could explore the potential of enforcing a minimum policy locally. Such a localised policy had been proposed in Manchester.

In response to questions raised by several members regarding the provision of cheap alcohol by supermarkets, Dr de Caestecker re-emphasised the importance of working with local supermarkets and multi-national companies at national level in an effort to find a balance. Councillor MacKay confirmed that local authorities could not stipulate what adverts appeared on local advertising boards. Councillor Coleman agreed that discussions with supermarkets were key but this was difficult to control as they were often huge national companies.

Dr de Caestecker agreed to include reference within the NHS Board's response to the social responsibility levy and this was welcomed.

DECIDED

That the NHS Board note the Health Impact Assessment (HIA) of Glasgow City Council Licensing Policy and support its recommendations. **Director of Public Health**

96. PROPOSED INTEGRATED SERVICE DELIVERY FOR ADDICTIONS: NHSGGC AND GLASGOW CITY COUNCIL

A report of the Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs [Board Paper No. 10/47] asked the NHS Board to note the proposed approach and arrangements for a joint approach to consider options to continue to have integration of the operational delivery of addiction services.

Ms Renfrew described the basis for change to current addiction services structures and outlined the components that would be included within the partnership agreement. The proposals focused on delivering integrated services with the key features of NHS and Social Care staff working in single teams, integrated assessment and care planning, a single access point for service users and aligned NHS and Social Care resources under the direction of a single management team. In summarising the single management structure, Ms Renfrew explained that this would deliver management cost reductions because of the move from five areas to three and the full integration of addiction service delivery into local NHS and Social Work structures.

In terms of next steps, she anticipated that a joint process would be established to appoint to key management roles from the existing pool of CHCP and Partnership addictions staff.

Thereafter, development of an interim partnership agreement detailing resources, joint roles, structure and accountabilities and the process to review and establish second tier structures including a joint finance role would take place. These processes would be conducted without delay to enable the transition from the current CHCPs to the new structures.

Mr Daniels sought clarity around the lines of accountability particularly in relation to the Head of Addiction/Addiction Services Lead post. Ms Renfrew confirmed that this post-holder would report to the Social Work Manager and NHS Sector Director and hoped that these two posts would be co-located. Such dual accountability would be carefully managed in accordance with the partnership agreement.

In response to a question from Mrs Smith, Ms Renfrew confirmed that NHS and Council colleagues were working collaboratively to progress this joint piece of work to ensure strategic partnership working in service delivery for addictions.

NOTED

97. MODERNISING AND IMPROVING MENTAL HEALTH SERVICES IN WEST DUNBARTONSHIRE IMPLICATIONS OF CHRISTIE WARD FIRE – 11 JULY 2010

A report of the Director of the Mental Health Partnership [Board Paper No. 10/49] asked the NHS Board to receive a further report in eight to ten months time identifying the impact on community services on adult acute metal health bed usage for the West Dunbartonshire, Helensburgh and Loch Side area and agree that, for the time being, beds for this area should be provided from Gartnavel Royal Hospital.

Mrs Hawkins outlined the background to the Clyde Mental Health Strategy and summarised developments since August 2008 when the NHS Board, as a consequence of a full consultation exercise on Clyde Mental Health Services, endorsed a series of significant service change proposals. In relation to North Clyde and, in particular, the Christie Ward, the Cabinet Secretary wished to reconsider the NHS Board's proposals in 12/18 months or sooner, should the demand for beds fall more rapidly, informed by a further report on the actual levels and trends in demand that were experienced. She also established a Monitoring Group to oversee the development and delivery of the service change plans affecting the Vale of Leven Hospital.

Mrs Hawkins summarised the work of the Vale Monitoring Group since it first met on 23 November 2009.

On 11 July 2010, a patient set fire to their room in the Christie Ward causing extensive damage. This necessitated the rapid movement of all patients and, on Monday 12 July 2010, 12 patients were moved to Gartnavel Royal Hospital. The Vale Monitoring Group met on 26 July 2010 and received a Monitoring Report and an initial report on the consequences of the fire. Since that time, the Monitoring Group had met on three occasions at which the discussions were wide ranging and detailed. The Chair of the Vale Monitoring Group had also communicated with the Cabinet Secretary.

In terms of options identified since the fire in the Christie Ward, Mrs Hawkins summarised six options identified with indicative associated costs. All options had a capital implication.

The very strong views expressed by the Monitoring Group were that capital should be made available in this financial year to allow the reopening of the Christie Ward. The Cabinet Secretary had expressed the view that a further period of monitoring take place and that repatriation of patients back to the Vale of Leven would not be in their, or their carers, best interest.

Councillor McColl as a member of the Monitoring Group, raised a motion "recommending the reinstatement of the Christie Ward or its equivalent, at the Vale of Leven with funding allocated and work commencing in the current financial year". He reaffirmed that there was a strong feeling from the community and the Monitoring Group that the Christie Ward should be reinstated. Mr Robertson sought a seconder for this motion. No seconder was received and the motion fell.

Councillor McColl referred to the area which was one of high deprivation and needs for Mental Health Services. He understood that West Dunbartonshire CHCP would be working to identify what further Mental Health Services could be provided from within the community if the Mental Health beds at the Christie Ward were not retained.

In response to a question from Mr Daniels regarding the preferred option (out of the six options listed), of the Monitoring Group, Councillor McColl reported that the Monitoring Group did not have a preferred option. They left this decision to the NHS Board but were clear that they wished the beds retained in West Dunbartonshire.

In response to a question from Councillor MacKay regarding the critical mass to declare a ward unsustainable, Mrs Hawkins confirmed that bed usage in the Christie Ward was running at around 12, on average, and this level was considered to be clinically unsustainable. This level of activity accounted for around 140 admissions per annum with an average length of stay between 21 and 40 days. Mrs Hawkins re-emphasised that most of this client group were cared for in the community.

Mr Williamson focused on the clinical side of this debate. He reiterated that Gartnavel Royal Hospital provided a far better level of care than the Vale of Leven. He recognised that whilst relatives were happy with the facilities provided, some found the journey to Gartnavel Royal Hospital more difficult than to the Vale of Leven. Mrs Hawkins agreed that, inevitably, the journey did take longer but that a further patient and carer survey would take place in the next one/two months with the outcome being reported to the Monitoring Group. She also explained that existing medical staff continued to manage patient care whilst they were in Gartnavel Royal Hospital. All clinical staff had adjusted to a new way of working which had maintained continuity of care for patients and their carers.

Mrs Dhir echoed Mr Williamson's comments and concluded that the quality of service to patients was paramount rather than the location. In integrating NHS Greater Glasgow and Clyde, much had been achieved in terms of quality of Mental Health Services within the Clyde community. She commended this work and the resultant reduction for the hospital beds within the Christie Ward.

 ACTION BY

DECIDED

- That the NHS Board receive a further report in eight/ten months time identifying the impact on community services on adult acute mental health bed usage for the West Dunbartonshire, Helensburgh and Loch Side area. **Director of the Mental Health Partnership**

- That, for the time being, beds for this area should be provided from Gartnavel Royal Hospital. **" "**

Councillor McColl asked that his dissent be recorded in respect of this decision.

98. OUTCOME OF HER MAJESTY'S INSPECTORATE OF EDUCATION (HMIe) REVIEWS

A report of the Nurse Director [Board Paper No. 10/46] asked the NHS Board to note the summary of two HMIe Joint Inspection of Services to Protect Children and Young People Reports, recognising that inspections were multi-agency.

Ms Crocket summarised the two HMIe inspection reports relating to East Dunbartonshire and East Renfrewshire. She explained that lessons learned from the inspections were progressed through a comprehensive range of governance structures. The inspections covered the range of services and staff working in each area who had a role to protect children. These included services provided by health, the police, the local authority and the Scottish Children's Reporter Administration, as well as those provided by voluntary and independent organisations. As part of the inspection process, inspectors reviewed practice through reading a sample of files held by services who worked to protect children living in the area.

Ms Crocket summarised the lessons learned from the inspections and highlighted particular strengths noted by the inspectors. She was pleased to report that both reports indicated that overall services were improving. Each Child Protection Committee had developed an action plan specific to their own report which would address the main recommendations and allow for monitoring and measuring progress.

In response to a question from Mrs Murray, Ms Crocket confirmed that relevant health staff were now involved more fully at an earlier stage particularly in relation to a medical opinion or a medical examination.

In relation to a point raised by Mrs Nijjar concerning the sharing of good practice, Ms Crocket reported that all HMIe reports were discussed at Child Protection Committees and the Chairs of these Committees met regularly to share best practice and lessons learned from inspections.

NOTED

99. WINTER PLAN 2010/11

A report of the Director of Emergency Care and Medical Services [Board Paper No. 10/48] asked members to note an update on the approach to winter planning 2010/11.

Mrs Grant explained that this was now the fifth year that NHS Greater Glasgow and Clyde had progressed winter planning as a single system approach. The membership of the Winter Planning Group included senior representation from all partner agencies and the Group met, during Winter, on a monthly basis and bi-monthly during the rest of the year. The Winter Planning Group had overseen the formulation of the Winter Plan for 2010/11 taking into account the lessons learned from 2009/10 and central advice. The escalation plan had also been revised and the NHS Board and other agencies continuity plans had all recently been updated.

Mrs Grant led the NHS Board through the key components of winter planning highlighting a number of key challenges and a focus on how these would be addressed. The National Emergency Access Delivery Team had identified the current financial challenges faced by Boards and the interface with local authorities (in particular, the impact of any changes to social care and home support services that may be effected as a result of the financial targets set) as key issues for Boards to address in preparing for Winter. In previous years, specific funding to support winter plan initiatives was available. In preparing for the 2010/11 Winter, the current financial climate had been recognised.

NOTED

100. ANNUAL UPDATE - FOOD FLUID AND NUTRITION

A report of the Nurse Director [Board Paper No. 10/50] asked the NHS Board to note the annual update on food, fluid and nutrition. Ms Crocket reported that the Food and Nutrition Planning and Implementation Group had prioritised the "achievement of a well nourished patient" objective within the implementation of the Board's Food, Fluid, and Nutrition Policy. Ms Crocket set out progress on the implementation of Food in Hospitals (national catering specification) and QIS Food, Fluid and Nutritional Care Standards.

In terms of future developments, Ms Crocket explained that a Hydration Policy had been drafted to support a standardised and multi-disciplinary approach to fluid provision and monitoring. In addition to the Patient Experience (Better Together) and annual catering satisfaction surveys as methods of seeking patient feedback, a specific patient engagement session was being held on 12 November 2010 to develop an objective bench mark for the patients "food journey". This session would validate an aspirational food journey, prioritise aspects of nutritional care and food provision and describe success. This would be used along with other feedback to focus improvement and to define patient centred outcomes and measures.

NOTED

101. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 10/51] asked the NHS Board to note progress against the national targets as at the end of August 2010.

Mrs Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets including out-patient waiting times, in-patient/daycase waiting times, diagnostic waiting times, accident and emergency four hour wait, cancer waiting times, chest pain, delayed discharge and stroke.

In response to a question, Mrs Grant reported that attendance at Accident and Emergency Departments was likely to continue to rise as greater pressure was placed on A&E Departments in the Winter months. Winter planning arrangements were currently being finalised and a number of initiatives involving direct admission of GP referrals were being put in place and refined.

In terms of delayed discharges, the NHS Board was required to maintain a performance standard of no patients waiting over six weeks for discharge. Mrs Grant reported that there continued to be individual circumstances where, due to case complexity, arrangements were not completed in accordance with the standard. Local Authority funding restrictions were now also starting to impact on the timely discharge of patients and this was under discussion between the respective Chief Executives.

NOTED

102. FINANCIAL MONITORING REPORT FOR THE 5 MONTH PERIOD TO 31 AUGUST 2010

A report of the Director of Finance [Board Paper No. 10/52] asked the NHS Board to note the Board's financial performance for the first five months of the financial year.

Mr Griffin explained that the NHS Board was currently reporting an expenditure outturn of £4M in excess of its budget for the first five months of the year. At this stage, however, the NHS Board considered a year end break even position remained achievable.

Mr Griffin outlined some of the reasons for the NHS Board reporting expenditure ahead of budget and explained that looking forward, there were some additional cost pressures which would have a bearing on the 2010/11 outturn, namely, the increased costs as a result of the recent national rates re-evaluation exercise, the increase in VAT (from 17.5% to 20%) which would occur in January 2011 and, a more recently recorded cost pressure, in expenditure relating to the dispensing of appliances. This was pushing Primary Care prescribing expenditure above budget for the first quarter of 2010/11 and could, if it continued, lead to an overspend on budget for the full year. Mr Griffin confirmed that this was currently being investigated to confirm the underlying cause and assess the potential full year impact.

In response to a question, Mr Griffin confirmed that, at this stage of the financial year, it was still premature to be making firm predictions of the likely outturn. There were some clear indications, however, based on trends to date, that expenditure levels were running at higher levels than the NHS Board would want to be confident that it could return to a break-even position by the year end.

Assuming that full achievement of the cost saving plans could be secured month on month from October 2010 onwards (and taking cognisance of the cost pressures noted) it was not unreasonable to anticipate that the NHS Board would require to identify around £10M of supplementary cost savings/cost reduction measures during 2010/11 if it was to succeed in managing expenditure within its revenue resource limit for the year.

Mr Griffin confirmed that a full review of the first half of the year outturn and any resultant action required would be discussed by the NHS Board's Performance Review Group meeting in November 2010.

NOTED

103. QUARTERLY REPORT ON COMPLAINTS – 1 APRIL TO 30 JUNE 2010

A report of the Head of Board Administration, Chief Operating Officer (Acute Services Division) and Director, Mental Health Partnership [Board Paper No. 10/53] asked the NHS Board to note the quarterly report on complaints in NHS Greater Glasgow and Clyde for the period 1 April to 30 June 2010 and note that a revised NHS Greater Glasgow and Clyde Complaints Policy had been developed and approved by the Corporate Management Team.

Mrs Grant summarised the statistical information on complaints handling for this period and highlighted areas of service improvements and ongoing developments. She recorded an overall complaints handling performance of 75% of all complaints being responded to within 20 working days (the national target was 70%).

In terms of the revised Complaints Policy, this had been approved by the Corporate Management Team at its meeting held on 14 September 2010. Although there were no significant changes of principle to the Complaints Policy, it had been rewritten to separate it from the Guidance and updated to reflect organisational changes, national documents and initiatives. Supporting documentation would now be prepared to underpin the re-launch of this policy such as revised leaflets, website review, posters and training.

Mr Williamson commended some of the service improvements and lessons learned made as a result of patient complaints. Not only were they interesting and informative to read, but demonstrated proactive action taken as a result of feedback from patients.

NOTED

104. UPDATE ON PROGRESS WITH ACTION FROM DIRECTOR OF PUBLIC HEALTH (DPH) REPORT, OCTOBER 2010

A report of the Director of Public Health [Board Paper No. 10/54] asked the NHS Board to note an update on progress with key actions from "An Unequal Struggle for Health, Report of the Director of Public Health 2009/2011". Dr de Caestecker led the NHS Board through the update reporting on progress taken forward in the priority areas for action. She reviewed how issues were being addressed and focussed on some key areas as follows:-

- Early Years – including focussing resources, supporting parents, addressing the social circumstances of families and children and changing attitudes towards children.

- Implications of the financial crisis for health and understanding the impact of the recession.

- Alcohol – the Public Health and Health Improvement Directorate continued to advocate for minimum pricing of alcohol and to provide briefings and information for local and national politicians.

- The population of NHS Greater Glasgow and Clyde needed to get more active.

- Health at Work – recognising the workplace as a community and providing information and training for workplaces on improving their environment and providing physical activity and healthy eating initiatives.

Furthermore, Dr de Caestecker summarised three key areas in preventative health approaches including anticipatory care, the falls and fracture liaison service and smoking cessation services. In summarising, Dr de Caestecker recorded that there had been substantial progress in taking forward the actions from "An Unhealthy Struggle for Health" but also areas where progress was more challenging particularly around the use of alcohol.

Renfrewshire CHP and Renfrewshire Council would jointly host an event to review action from the report on 10 November 2010 and Dr de Caestecker extended an invitation to all members to attend this event.

In response to a question from Mr Robertson, Dr de Caestecker confirmed that Health at Work had 228 organisations across Greater Glasgow and Clyde registered – this covered 189,723 employees. She explained that awards were presented in gold, silver and bronze.

Mrs Nijjar raised a concern that Cordia, the company contracted with Glasgow City Council to provide school meals, now sold cakes and biscuits which was of concern. Dr de Caestecker continued to advocate healthy eating in schools with both Cordia and Glasgow City Council and had written regarding the decision to provide such snacks. Cordia had reported that the snacks met national nutritional standards. Nonetheless, Dr de Caestecker confirmed that she would continue to advocate and monitor the effect of that decision but that data would need to be collected to support and evaluate the sale or otherwise of these snacks.

NOTED

105. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003 : LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 10/55] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

ACTION BY

DECIDED

That the six Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

106. CLINICAL GOVERNANCE COMMITTEE MINUTES: 3 AUGUST 2010 AND 5 OCTOBER 2010

The Minutes of the Clinical Governance Committee meetings held on 3 August 2010 and 5 October 2010 [CGC(M)10/04] and [CGC(M)10/05] were noted.

NOTED

107. AREA CLINICAL FORUM MINUTES: 5 AUGUST 2010

The Minutes of the Area Clinical Forum meeting held on 5 August 2010 [ACF(M)10/04] were noted.

NOTED

108. PHARMACY PRACTICES COMMITTEE MINUTES: 23 AUGUST 2010

The Minutes of the Pharmacy Practices Committee meeting held on 23 August 2010 [PPC(M)10/06] were noted.

NOTED

109. STAFF GOVERNANCE COMMITTEE MINUTES: 7 SEPTEMBER 2010

The Minutes of the Staff Governance Committee meeting held on 7 September 2010 [SGC(M)10/03] were noted.

NOTED

110. PERFORMANCE REVIEW GROUP MINUTES: 21 SEPTEMBER 2010

The Minutes of the Performance Review Group meeting held on 21 September 2010 [PRG(M)10/05] were noted.

NOTED

The meeting ended at 13:05 p.m.

Greater Glasgow & Clyde NHS Board

Board Meeting Paper No.10 /44

26th October 2010

Full Business Case - New South Glasgow Adult and Children's Hospitals

RECOMMENDATION

Board members are asked to receive this paper which details the key points in the Full Business Case (FBC) for the New South Glasgow Hospitals and to approve the Full Business Case. The proposals set out in this document are fully in line with the phased construction contract signed between NHS Greater Glasgow and Clyde and Brookfield Construction UK Limited (BCL) in December 2009.

It is planned to submit the FBC to the Capital Investment Group (CIG) for consideration at their meeting on 9th November 2010.

Copies of the Full Business Case are available on request.

Structure of the document

This document describes the strategic context of the project and the actions undertaken since Outline Business Case approval. The remaining sections outline the scope of the new hospitals, the Stage 2 design work undertaken, expected benefits of the project, governance and contractual arrangements, risk management, financial appraisal, status of planning permission, economic benefits to the local community and the outcome of the recent Gateway Review.

1. Recap on Purpose of the Project

The New South Glasgow Hospitals (consisting of a new adult and new children's hospital), represent the second phase in the Acute Services Review strategy (ASR). The ASR proposes the reduction in the number of acute adult sites from 6 to 3, these being Glasgow Royal Infirmary, the new South Glasgow campus and Gartnavel General Hospital and the development of two ambulatory care hospitals at the Stobhill and Victoria sites.

The strategy is well underway with the first phase, the development of the two Ambulatory Care Hospitals, completed in 2009.

The New South Glasgow Hospitals will achieve the gold standard triple co-location of adult, children's and maternity services and modernise services, facilitating the closure of the Western Infirmary, the Victoria Infirmary, Mansion House, Yorkhill Hospitals and some existing parts of the Southern General Hospital with the transfer of inpatient services to new, state of the art facilities.

The construction of the new hospitals will give the opportunity to redesign the way in which health services are delivered and to reappraise the skills and profile of the workforce to deliver modern health services for the 21st century.

The development also has the potential to breathe new life into South West Glasgow and beyond, generating jobs and commercial opportunities for the local population both during construction and once in operation.

2. OBC Approval

The proposals for a new adult and children's hospitals, new laboratory facility, facilities management and new 33kv electrical sub-station were previously presented to the Scottish Government in an Outline Business Case (OBC) which was approved in May 2008.

Procurement Process

Subsequent to OBC approval in May 2008 the Board commenced a procurement process to contract to design and build the new hospitals and laboratory facility which concluded in October 2009.

The outcome of the procurement was presented to the Board in November 2009. The Board approved the signing of a contract with Brookfield Construction UK Limited which was complete on 18th December 2009. The contract made provision for:-

- Stage 1- construct the new laboratory, the FM facility and the new 33kv electrical substation

- Stage 2 - design the new adult and children's hospitals which will inform the work for the Full Business Case (FBC)

Upon Scottish Government approval of the new adult and children's hospitals FBC, BCL are contracted to complete stages 3 and 3a below

- Stage 3 - construct the new adult and children's hospitals

- Stage 3a - Demolition of the surgical block and associated buildings and completion of the soft landscaping

Timetable

A summary timetable for the project is shown below.

Event	Milestone
Stage 1 commence construction of the Labs project	February 2010
Stage 2 completion, Full Business Case (FBC) approval by Health Board	26 October 2010
FBC considered by Scottish Government Capital Investment group	November 2010
Stage 3 (Construction of adult and children's hospitals) programmed to commence	November 2010
Stage 1 Completion (Construction) - Laboratory Facilities	March 2012
Stage 3 Completion (Construction) – adult and children's hospital	January 2015
Operational Date – adult and children's hospital complete service transfers.	Summer 2015
Stage 3a completion, demolition of surgical block and completion of landscaping	Summer 2016

New Laboratory Build

A Full Business Case for the laboratory and FM component was approved by the Scottish Government on 4th December 2009. Building work commenced in February 2010 and is anticipated to complete on 10th March 2012. The construction work is on schedule and within the project budget with a governance structure, risk management and change control process fully established.

This document therefore addresses the remaining components of the contract which are a new adult hospital and new children's hospital.

The following describes the scope of the new hospitals and the Stage 2 design work undertaken, expected benefits of the project, governance and contractual arrangements, risk management, financial appraisal and outcome of the recent Gateway Review.

3. Scope of the Adult and Children's hospitals

New Adult Hospital

A 1,109 bedded adult new build acute hospital is planned providing A&E services and acute specialist in-patient care, a small volume of medical day cases and out-patient clinics serving the local (South-West Glasgow) population. No day surgery will be undertaken as this will be provided at the new Victoria Hospital.

New Children's Hospital

The proposed new 256 bedded children's hospital will provide A&E services and a comprehensive range of inpatient and day case specialist medical and surgical paediatric services on a local, regional and national basis. The new development will also have outpatient facilities. The Board's strategy is that all Glasgow's children's services (up to the age of 16 and up to 18 years where appropriate) will be provided at the new children's hospital.

4. Anticipated benefits from the project

The project will provide a wide range of benefits some of which have already been mentioned. In brief the new adult and children's hospitals on the southern site will bring together adult, children's and maternity services to provide a triple co-location gold standard service.

The bringing together of inpatient services from the Western Infirmary, the Victoria Infirmary and some existing parts of the Southern General Hospital will allow continued sustainability of clinical services, sustained achievement of working time directives and 'Reshaping the Workforce' and larger specialist teams to be formed with 24/7 patient access to high quality specialist services. The consolidation of 3 sites to 1 will enhance opportunities for teaching and research and strengthen links with the Universities.

The new build will allow critical co-locations between departments and within departments to be addressed and patient pathways to be remodelled producing a more efficient service. This will allow the Board to continue to meet the Government HEAT targets and increased ability to meet future waiting time guarantees for 2015.

The new hospitals will be designed to be fit for purpose and will provide a pleasant healing environment with single rooms and ensuite facilities for the adult hospital and separation of patients, visitors and Facilities Management travel routes. The healing environment will be enhanced through the development of an arts strategy the key strategic elements of which are incorporated into the contract.

The new buildings are designed to address environmental issues in energy consumption and carbon footprint and will provide a good working environment which will enhance staff morale and recruitment and retention. The new builds will also allow innovative solutions for materials management and logistics.

5. Stage 2 Design work undertaken.

The tender documentation set a minimum level of design information required for the Full Business Case, this included development of the departmental layouts (1:200 drawings), the individual rooms layouts (1:50 drawings) and a range of technical aspects such as: facilities management systems, equipment, acoustics, electrical systems, fire strategy, access and security systems, surface finishes and protection and radiation protection,

Pre-contract, over 70 user groups were involved in the development of the schedules of accommodation, clinical output specifications, identification of key critical co-locations and, for the podium specialties, development of exemplar drawings. Following award of the contract the user groups have been working closely with the Project Team and Contractor's architectural team to develop the detailed design of their departments, the following describes this in more detail.

Between January 2010 and June 2010 each user group met 2 or 3 times with the Project Team and Architects to develop the layout of their departments, this involved looking at patient flows through the department and to other departments, flows of clean and dirty goods and critical adjacencies of rooms. The 1:200 drawings were signed off in June by the user groups and a project review by the Project Team and Advisers was completed in August 2010.

In the period June to September 2010 work was undertaken with the user groups in developing the 1:50 typical room drawings. This involved one to two user meetings with each group reviewing, in total, over 700 different room types identifying the equipment, fittings and fixtures, medical gases etc which will be required in each room and their appropriate locations.

Full size mock-ups of an adult bedroom and en-suite, child's bedroom and en-suite with staff touchdown and a critical care space were built to assist users in developing the individual room layouts (1:50 drawings). This has proved to be extremely helpful in progressing the design.

Within the two new hospitals all briefed room sizes follow the building note guidance but the 1:50 process allowed minor adjustments and final check that the room size was fit for function. The information gathered during the 1:50 process was used to confirm the capital equipment costs.

The membership of the user groups include medical, nursing, Allied Health Professions, Facilities Management, Diagnostic and pharmacy staff. In addition the user groups are supported by input from medical physics and IT and, where required, radiological protection officers. It should be noted that infection control have been fully involved in the design with a senior infection control nurse as a full time member of the Project Team attending all the user group meetings.

The new hospitals incorporate state of the art design and equipment with a range of innovative features including the use of automated guided vehicles to provide transportation of catering and supplies around the hospital, advanced Information Technology supporting a paper-lite environment, a roof top helipad, a high tech Building Management System, in-built resilience and a range of low to zero carbon technologies.

6. Governance Arrangements

The project has demonstrated and followed good management processes and has robust risk management and governance structures in place. The governance structure continues to be reviewed and reconfigured in response to the changing needs of the project through each different stage. There is a strict change control mechanism in place, the success of which is demonstrated by the cost of the project remaining stable since contract award in December 2009. The project is subject to regular external audit and there is close liaison with the Scottish Government regarding direction and progress of the project.

7. Risk Management

Risk Management has been, and remains, a primary focus in the management of the Project.

From the outset of the procurement process the Project Team have completed a Risk Register of the Boards risks and this will be continually maintained throughout the life of the Project. The risk register is reported to the Acute Services Redesign Group each month.

In developing all aspects of planning the new facilities the Project Team and advisors have pro-actively managed potential risks by early identification and action to ensure maximum reduction and mitigation of risk. This approach has been enacted at all key stages of the project including pre-procurement, during procurement and post procurement and has included actions such as market sounding, consultation with key organisations, community engagement, robust control of change and ensuring the site to be handed over to the contractor is clear with known ground conditions.

As part of the contract agreement with BCL the Board and the Contractor each have an agreed risk allocation. Risk is jointly managed between the Board and BCL with regular formal reviews pre-planned, and weekly reviews undertaken to proactively manage identified and new risks.

8. Contract Arrangements

The contract between The NHS Greater Glasgow and Clyde and BCL is in accordance with NEC3 Conditions of Contract Option C Target Price. This means that there is collaborative working between the Board and BCL in taking the project forward

In recognition that the Contractor has formally committed to contract for the Design & Build of the Hospitals at a relatively early stage in the design life cycle, the Contract has been varied to introduce the principal of shared risk within a Target and Maximum Price threshold. This means that if outturn costs are less than the Target the Board and Contractor share in any savings at pre agreed ratios. Where outturn costs are above Target then there is a share of the overrun costs at pre agreed ratios and should outturn costs exceed the Maximum Price then any liability for the Board to make further payments stop, and the Contractor absorbs 100% of the overrun.

The sharing of risks or risk allocation in the contract agreement was agreed during the competitive dialogue process by the Commercial Group, (this group are part of the governance structure for the project).

A number of key contract risks have already been mitigated through work undertaken over the past months, these include the following:

- 1:200 process now concluded
- Development of the 1:50 typical rooms types has also been concluded
- Master Planning Approval given with section 75 costs agreed.
- Scottish Ambulance Service and Scottish Water land purchase costs agreed and on programme for transfer.
- A comprehensive set of design deliverables have been completed during Stage 2.
- The recent rise in VAT to 20% has been accounted for within the current budget
- Demolition to clear the site for the new hospitals is on programme and budget

Of the residual contract risks the key risks which lie with the Board are:

- The finalisation of the 1:50 room layout and equipment
- The helipad relocation
- Inflation risk above 2.5% per annum over the contract duration

As stated above, these are monitored on a regular basis.

9. Economic Appraisal

In order to ensure that the project continues to provide the Board with optimum value for money the original options considered at the Outline Business Case were reconsidered and it was confirmed that the proposal for new Adult and Children's Hospitals at the Southern General Campus, with the retention of some existing buildings e.g. Neurosciences and Maternity, remains the preferred option.

The OBC also considered three potential procurement routes, i.e. traditional procurement, Private Finance Initiative (PFI) and Not for Profit Distribution Model (NPD). The NPD model provides for the redistribution to the Board of any excess profit which may arise in the form of a "charitable surplus".

In conjunction with the Board's Financial Advisors the three procurement routes were retested and it was confirmed that the traditional procurement route continued to deliver substantially better value for money than both the PFI and NPD options.

10. Financial Appraisal

As part of finalising the FBC an exercise was undertaken to recalculate both the capital and revenue consequences of the New South Glasgow Adult and Children's Hospitals to ensure that the preferred solution continues to be affordable in both capital and revenue terms.

The original contract value agreed with the preferred bidder in December 2009 for the construction of the Hospitals was confirmed as being within the overall affordability envelope. Since contract award, strict change control procedures have ensured minimal change to this contract value. The aggregate of the contract value at October 2010, and all other associated costs including equipment, fees, other non-works costs, Value Added Tax (at the 20% rate applicable from January 2011) and a reasonable provision for quantified risk agreed in conjunction with professional advisors, remain within the overall capital budget for the project.

The impact the project will have on the Board's revenue position has also been revisited during the preparation of the FBC.

The updated cost estimates confirm that by proceeding with the project, the Board is forecasting the achievement of a net revenue saving of £18m. This saving arises partly due to a reduction in Capital Charges to be incurred on the new Hospitals and partly through service savings.

11. Planning Consent

Outline Planning consent was granted in July 2009, based upon the exemplar scheme and subject to 43 conditions and a Section 75 Agreement for off site works.

Between February and September 2010 workshops were held with Glasgow City Council Department Regeneration Services (DRS) and relevant stakeholders to develop the design in 4 key areas, these being – architectural, landscape, transportation and roads/drainage.

In June 2010 planning consent was granted for the Masterplan Matters Specified in Conditions (MSC) application, based on the BCL scheme.

Architectural and other pre-start MSC application was submitted in July 2010. As only one objection was raised the Planning Consent will be dealt with under delegated powers by officers without reference to their Planning Committee. Approval is expected in October 2010.

12. Community Economic Benefits

In order to realise potential regeneration opportunities to South West Glasgow and beyond targets were set in the contract to support local recruitment and small /Medium Enterprises (SME') and Social Enterprises (SE).

In brief 10% of recruits are to be new entrants and BCL are working in partnership with Glasgow South West Regeneration Agency and Glasgow City Council training and supporting local businesses to tender for work on the project.

13. Outcome of Gateway 3

A Gateway 3 Review was undertaken by the Office of Government and Commerce Gateway Review Team between 4th-6th October 2010. The project was awarded a green level of Delivery Confidence Assessment, defined as: "successful delivery of the project/programme to time cost and quality appears highly likely and there are no major outstanding issues at this stage that appear to threaten delivery significantly".

The Gateway report is very positive and recommends that the project should develop a case study of the procurement approach (so this could be shared with other NHS and Government organisations). There are two actions highlighted to be completed before the next Gateway Review and these are to add some indirect risks (e.g. political risks) to the risk register and continue to develop the benefits management plan to define targets and gather baseline data.

14. Recommendation

Board members are asked to receive this paper which details the key points in the Full Business Case (FBC) for the New South Glasgow Hospitals and to approve the Full Business Case. The proposals set out in this document are fully in line with the phased construction contract signed between NHS Greater Glasgow and Clyde and Brookfield Construction UK Limited in December 2009.

NHSGG&C(M)13/03
Minutes: 40 - 62

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Corporate Headquarters, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH on Tuesday, 25 June 2013 at 9:30a.m.

PRESENT

Mr A O Robertson (in the Chair)

Dr J Armstrong	Mr P James
Dr C Benton MBE	Dr M Kapasi MBE
Ms M Brown	Mr I Lee
Mr R Calderwood	Councillor M Macmillan
Ms R Crocket	Ms R Micklem
Mr P Daniels OBE	Dr R Reid
Dr L de Caestecker	Councillor M Rooney
Councillor M Devlin	Rev Dr N Shanks
Mr R Finnie	Mr D Sime
Mr I Fraser	Mr K Winter

IN ATTENDANCE

Ms S Gordon	Secretariat Manager
Ms J Grant	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	Head of Board Administration
Mrs A Hawkins	Director, Glasgow City CHP
Mr A McLaws	Director of Corporate Communications
Mr I Reid	Director of Human Resources
Ms J Truman	Senior Researcher, Public Health (for Minute 48)

ACTION BY

40. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr G Carson, Prof A Dominiczak, Councillor M Kerr, Councillor A Lafferty, Councillor J McIlwee, Councillor M O'Donnell, Mrs P Spencer BEM and Mr B Williamson.

Mr Robertson welcomed Councillor Maureen Devlin to her first NHS Board Meeting representing South Lanarkshire Council (replacing Councillor J Handibode). He also recorded that this would have been the last NHS Board meeting for Mrs P Spencer as her term of office expired on 30 June 2013. Unfortunately, Mrs Spencer was currently absent but he paid tribute to her contribution to the work of the Area Clinical Forum as its Chair, the NHS Board and its Committees and sent his best wishes, on behalf of the NHS Board, for her future.

Mr Robertson congratulated current and former members of staff who had received an honour in the birthday honours list announced on 22 June 2013, namely, Alice Docherty MBE, Margaret Smith OBE, Elizabeth Stowe MBE and Ian Anderson CBE.

NOTED

41. DECLARATION(S) OF INTEREST(S)

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

NOTED

42. CHAIR'S REPORT

(i) Mr Robertson reported that he had completed this year's round of Non-Executive NHS Board Member appraisals.

(ii) On 23 April 2013, Mr Robertson welcomed the First Minister, Alex Salmond MSP, to the new Southern General Hospital where a new Innovation Centre (focussing on stratified medicine and innovation) would be built. This was one of three new Innovation Centres launched by the First Minister supported by £30m of public funding to concentrate on developing world-leading Scottish technology and life sciences.

(iii) Following the Chairman's awards ceremony in November 2012, Mr Robertson visited many of the nominees where he had been most impressed with the dedication and commitment of staff, facilities and overwhelmed by the sense of teamwork to ensure better experiences for patients.

(iv) On 1 May 2013, Mr Robertson attended a meeting of the National Group on Community Planning Reform of which he was a member and on 8 May 2013 he also attended a meeting of the Ministerial Strategy Group for Health and Community Care. These meetings would have a bearing on development of Integration of Health and Social Care delivery and it was important that NHSGGC was represented.

(v) On 11 and 12 June 2013, the annual NHS Scotland event was held in the SECC. Mr Robertson and other NHS Board members had attended.

(vi) On 13 June 2013, Mr Robertson visited the Trakcare project team at Glasgow Royal Infirmary. Trakcare was a patient administration IT project being rolled out across NHSGGC resulting in significant improvements in the use of technology. The initial work had been completed and the team was ensuring that outstanding difficulties were being dealt with.

(vii) On 20 June 2013, Mr Robertson and other Executive NHS Board members met with representatives from NHS Education for Scotland (NES) for their joint engagement annual meeting.

(viii) On 24 June 2013, Mr Robertson presided at the Topping Out Ceremony on the top floor of the Adult Hospital at the New South Glasgow Hospital Campus. This milestone was conducted by the Cabinet Secretary for Health and Wellbeing, Alex Neil MSP and marked the final stages of a journey which started back in 2001 and saw NHSGGC deliver a programme of investment of almost £2bn in modernising healthcare accommodation across Acute, Mental Health and Primary Community Care.

(ix) Mr Robertson congratulated Mr Calderwood who had been granted the status of Honorary Professor in the Adam Smith Business School (University of Glasgow) from 1 May 2013 until 30 April 2018.

NOTED

43. CHIEF EXECUTIVE'S UPDATE

(i) On 18 April 2013, Mr Calderwood met with the Cabinet Secretary for Health and Wellbeing, Alex Neil MSP, along with Professor Anton Muscatelli, Principal and Vice Chancellor, University of Glasgow and Professor A Dominczak to present an update on the NHS/University's plans and progress being made on initiatives at the New South Glasgow Hospital site. In particular, they discussed clinical research facilities and, at the invitation of the Cabinet Secretary, Mr Calderwood was invited to submit a proposal to him regarding a diagnostic imaging research facility to augment overall research facilities currently planned for the campus.

(ii) On 9 May 2013, Mr Calderwood and Ms J Grant hosted a visit, on behalf of the SGHD, for healthcare executives as part of a Premiere IHI International Study Tour to stimulate learning by USA healthcare executives about what they could adapt from non-USA systems that might allow them to be more successful under USA health reforms. The participants visited the New South Glasgow Hospital and looked at how, using investment as part of a modernisation and change programme, new clinical services and a new building were giving that opportunity.

(iii) On 13 May 2013, Mr Calderwood and Dr J Armstrong met with Duncan McNeil MSP to discuss health provision in Inverclyde and the NHS Board's Clinical Services Review.

(iv) On 22 May 2013, Mr Calderwood met with the Chief Executive of Renfrewshire Council, Mr D Martin, to discuss the integration of health and social care services. He confirmed that the plans for the integration of health and social services would result in new governance Boards being established.

(v) On 13 June 2013, Mr Calderwood attended a NHSGGC shop steward's development day which offered the opportunity for shop stewards/lay representatives of trade unions/professional organisations to hear views about the Board's organisational development programme "Facing the Future Together" (FTFT). Mr Calderwood had addressed the audience and enjoyed the debate.

(vi) Also on 13 June 2013, Mr Calderwood met with the Chief Executive of Glasgow City Council to consider implications for local systems in Glasgow in light of the forthcoming legislation that would require integration of adult health and social care. Mr Calderwood reported that it was the intention to move to a shadow form during 2014/15 and, given this timetable, Mrs A Hawkins had agreed to delay her retirement until April 2014 to lead the project of integration with Glasgow City Council. Given this, it had been agreed not to progress with the recruitment of the replacement for Mrs Hawkins (as Director of Glasgow City CHP) until the NHS Board received and agreed an integration project plan.

(vii) On 21 June 2013, Mr Calderwood attended the "Releasing Time to Care" (RTTC) Board Event held at Hampden Park where he had been a speaker. The presentations had been thought-provoking and had encouraged interesting debate and discussion concerning the fundamental importance RTTC played in creating a patient-centred programme.

(viii) Mr Calderwood extended his congratulations to Ms J Grant who had been appointed Chief Executive of NHS Forth Valley and would take up her new post on 1 October 2013.

(ix) Mr Calderwood reported that the Cabinet Secretary for Health and Wellbeing had offered him the appointment of Stakeholder non executive member on the NHS National Services Scotland Board. The appointment was for four years from 1 June 2013.

NOTED

44. MINUTES

On the motion of Mr I Fraser, seconded by Dr M Kapasi, the Minutes of the NHS Board meeting held on Tuesday, 16 April 2013 [NHSGG&C(M)13/02] were approved as an accurate record and signed by the Chair.

NOTED

45. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was noted.

(ii) In response to a question from Councillor McMillan, Mr Calderwood confirmed that the NHS Board's car parking policy and arrangements would be discussed at the NHS Board Meeting scheduled for August 2013. **August 2013 Board Agenda**

(iii) In response to a question from Councillor Rooney regarding the Homeopathic Hospital, Mr Calderwood confirmed that the NHS Board was working with staff at the Homeopathic Hospital to undertake a programme of service redesign to ensure a balance of outpatient/day services and inpatient services. Mr Calderwood also alluded to the Cabinet Secretary for Health and Wellbeing's announcement confirming a Scottish-based Chronic Pain service and he reported that it was the NHS Board's intention to work with staff at the Homeopathic Hospital so they could be involved in taking that service forward.

(iv) In response to a question from Councillor Rooney regarding the offsetting of additional non-recurring savings against other budgets, Mr Calderwood reported an in-year on-balance of non-recurring monies in 2012/13.

(v) In response to a question from Councillor Rooney concerning the major development to immunisation programmes in the UK starting from July 2013, Dr de Caestecker confirmed that the associated media work to be undertaken would be led by a national campaign with local work simultaneously being held. Ongoing discussions were taking place with GP colleagues concerning the payment schedule particularly as the Scottish Government Health Directorates had confirmed it would pay only for the vaccinations themselves and not for their administration.

NOTED

46. SCOTTISH PATIENT SAFETY PROGRAMME

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 13/20] asked the NHS Board to review and comment on the ongoing progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Armstrong reported that NHSGGC had recently responded to a request from Healthcare Improvement Scotland (HIS) to outline progress across the Adult Acute Care programme. She led the NHS Board through progress in implementation and summarised the elements in each of the four drivers, namely, general ward, critical care, perioperative care and medicine reconciliation. She explained that the Acute Service Division's Clinical Governance Forum was responsible for ongoing implementation and had created an explicit general ward driver as part of key divisional safety objectives. The current position confirmed high levels of involvement and progress to reliable processes.

In terms of critical care and perioperative care, significant progress was apparent and the Acute Services Division was reviewing how programme support could move from improvement interactions to maintenance.

Dr Armstrong explained that when SPSP was established, there was a national measurement strategy that included two explicit overarching aims one of which was to create a 15% reduction in hospital mortality. As a result, the Hospital Standardised Mortality Ratio (HSMR) was established and Information Services Division (ISD) had produced quarterly HSMR reports since December 2009 for all Scottish hospitals participating in the SPSP. The governance of HSMR was embedded in reviews of SPSP implementation given that reducing hospital mortality was a fundamental element of the SPSP. NHSGGC was approached by NHS Health Improvement Scotland (HIS) in 2010 as indications showed that the Royal Alexandra Hospital (RAH) had not been reducing the HSMR in line with the national average and so appeared as an outlier through a comparative review. Given this, Dr Armstrong explained that a review and action plan was established and proved successful with the NHS Board then receiving confirmation of acceptability by HIS on reducing the HSMR at RAH.

In response to a question from Councillor Rooney regarding the HSMR combined measure for both the RAH and the Vale of Leven hospitals, Dr Armstrong explained that this was due to changes in patient pathways. At the time in 2010 when approached by NHS HIS, these were separate measures as the Vale of Leven Hospital was not directly involved in the NHS Board's focused improvement activity. The HSMR figures were now monitored as an aggregate of both hospitals.

NOTED

47. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 13/21] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.
In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. For the last available reporting quarter (October to December 2012), NHSGGC reported 27.6 cases per 100,000 Acute Occupied Bed Days (AOBDs). NHS Scotland reported 29.9 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 (AOBDs) or lower by 31 March 2015.

The national report published in April 2013 (October to December 2012) showed the rate of C.difficile within NHSGGC as 17.8 per 100,000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean (26.7 per 100,000 OBDs in over 65s). The revised HEAT target required Boards to achieve a rate of 25 cases per 100,000 OBDs in all patients (previously, the target only included patients 65 years and over) to be attained by 31 March 2015.

For the last available quarter (January to March 2013), the surgical site infection (SSI) rate for caesarean sections and reduction of long bone fracture procedures were below the national average, however, the rate for hip anthroplasty, knee anthroplasty and repair of neck femur procedures were above the national average although all remained within 95% confidence intervals. Surveillance continued.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 2,929 members of staff who were now registered as Cleanliness Champions.

Councillor Rooney asked about the unannounced inspection of Gartnavel General Hospital, conducted by the Healthcare Environment Inspectorate (HEI) on 26 March 2013. Their resultant findings and requirements in terms of taking forward the recommendations did not appear to have timelines attached to them. Ms Crocket reported that the NHS Board was obliged to provide the HEI with a progress report within 16 weeks. This was currently being worked on and she led the NHS Board through some of the actions already taken. She also alluded to some of the very positive remarks made following the inspection at Gartnavel General Hospital and was encouraged that staff felt confident and comfortable raising concerns about good and bad practice.

Mrs Brown referred to the outbreak of three group A streptococcus patients identified in Ward 37 of the RAH within 19 days. Dr Armstrong confirmed that the environmental audit carried out on 15 March 2013 which scored 64% was low and disappointing and highlighted the raft of measures being put in place to improve upon this. Mr Calderwood added that this was an adult mental health admissions ward and agreed that the audit was disappointing but alluded to some immediate action that had taken place to rectify some points concerning the structure of the building and its fabric.

NOTED

48. ADULT HEALTH AND WELLBEING SURVEY TRENDS REPORT 1999-2011

A report of the Director of Public Health [Board Paper No 13/22] provided a summary of the key trends from 1999 to 2011 allowing the NHS Board to monitor changes across the area, within CH(C)Ps, between the most deprived areas and other areas and between age groups and gender.

Dr de Caestecker led the NHS Board through the following ten noteworthy key results from the 2011 survey as follows:-

a) There had been a modest but steady decline in smoking since the survey began. This decline had been most marked in the most deprived areas.

b) There had been a dramatic reduction in the proportion of respondents exposed to environmental tobacco smoke. The ban of smoking in public places must have made an impact in this area.

c) The proportion of respondents that exceeded the recommended limits for alcohol in the previous week had reduced. This corresponded to a decrease in alcohol related death and a decrease in alcohol related admissions seen in routinely collected hospital and death data.

d) There had been no change in the proportion of respondents that met the physical activity target.

e) There had been an increase in the proportion of respondents that ate five portions of fruit and vegetables per day. The gap between the most deprived areas and other areas, whilst still present, was starting to close.

f) There had been an increase in the proportion of respondents that had a positive perception of quality of life.

g) There had been an increase in the proportion of respondents that had a positive perception of their local area as a place to live.

h) The proportion of respondents that felt safe in their own home had increased. There was no longer a difference in this aspect of health and wellbeing between the bottom 15% areas and other areas.

i) The proportion of respondents with no educational qualifications had decreased. This may be due to the changes in the range of qualifications available and increased flexibility in which to gain educational qualifications.

j) There was a persistent gap between the most deprived areas and other areas in the proportion of respondents who would be able to meet unexpected bills of £20, £100 or £1000.

These top ten messages demonstrated areas where improvements had been made and also areas of continuing challenge. Dr de Caestecker alluded to some explanations for these contained within the report as well as other observations and highlights where the NHS needed to improve its practice and policy.

Ms Micklem commended the report and some of the really encouraging results but mused at how accurate any result could be when it was reliant on self-reporting. Ms Truman agreed that it was difficult to establish how accurate (or otherwise) the information was when the survey relied on the honesty of those completing it. One example of this was the sale of alcohol not correlating with the results found in the survey.

Dr Reid noted that there had been no change in the proportion of adults who had used A&E Departments over the previous years. Ms Truman reported that the data collected concerned "A&E" and not attendance at a Minor Injuries Unit (MIU). In response to a further question from Dr Reid, she confirmed that NHS 24 began operating in 2004.

Rev Dr Shanks commended the methodology used and suggested it would be useful to include regression lines in all the graphs throughout the report. Ms Truman agreed to include these prior to further distribution of the report. **Director of Public Health**

NOTED

49. GOVERNANCE STATEMENT 2012-13

A report of the Convenor of the Audit Committee [Board Paper No 13/23] comprising a Statement of Assurance by the Audit Committee and a Governance Statement, which

was part of the Annual Accounts for 2012/13, was submitted. Subject to approval of this report, the NHS Board was asked to authorise the Chief Executive to sign the Governance Statement as the Accountable Officer.

The Convenor of the Audit Committee, Mr K Winter, presented the report.

The Audit Committee, at its meeting on 4 June 2013, received a report which provided members with evidence to allow the Committee to review the NHS Board's system of internal control for 2012/2013. Based on the review of internal control, the Audit Committee approved both the Statement of Assurance to the NHS Board on the system of internal control within NHS Greater Glasgow and Clyde and the Governance Statement for NHS Greater Glasgow and Clyde.

Mr Winter took the NHS Board through Appendix 1 – Statement of Assurance by the Audit Committee and Appendix 2 – Governance Statement. He reported that there were no significant matters relating to the system of internal control which required to be disclosed in the Governance Statement and that the Audit Committee recommended that the NHS Board approve the Governance Statement and that this be signed by the Chief Executive as Accountable Officer.

DECIDED

1. That the Statement of Assurance from the Audit Committee be accepted and noted. **Director of Finance**

2. That the Governance Statement be approved for signature by the Chief Executive. **Chief Executive**

NOTED

50. STATEMENT OF ACCOUNTS FOR 2012/13

A report of the Director of Finance [Board Paper No 13/24] asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorate (SGHD), the Statement of Accounts for the financial year ended 31 March 2013.

Mr James introduced the Accounts which had previously been considered in draft form by the Audit Committee. He advised that the Revenue Resource Limit and Capital Resource Limit had both been achieved.

The Accounts were prepared, as required, to comply with the requirements of International Financial Reporting Standards (IFRS) and in a format required by SGHD, so that these could be consolidated with the accounts of other NHS Boards to form the accounts of NHS Scotland.

The Audit Committee considered the Director of Finance's report at its meeting on 4 June 2013, and the final draft set of accounts at its meeting on 19 June 2013. As a consequence, the Audit Committee could confirm to the NHS Board meeting that they recommended that the NHS Board adopt the Accounts for the year to 31 March 2013.

Mr James advised that at its meeting on 19 June 2013, the Audit Committee received confirmation from Audit Scotland of its intention to issue an unqualified opinion in respect of the financial statements, the regularity of financial transactions undertaken by the NHS Board and on other prescribed matters.

ACTION BY

Mr James confirmed that the NHS Board's financial statements disclosed that the NHS Board had met its financial targets. He took members through the key elements of the accounts including the Operating Cost Statement, Balance Sheet and Cash Flow Statement to the year ended 31 March 2013. Mr James summarised the main issues arising from his report and confirmed that Audit Scotland's opinion was that the financial statements gave a true and fair view of the accounts.

At the request of Mr Finnie, Mr James reiterated that the responsibility rested with each Board Member on an individual basis, so far as each was aware, that there was no relevant audit information of which the Board's auditors had not been made aware; and each had taken all steps they ought reasonably to have taken as a Director to make themselves aware of any relevant audit information and to establish that the Board's auditors had been made aware of that information.

Mr James took the opportunity to thank his finance staff and Audit Scotland for their assistance in producing and auditing the Accounts.

DECIDED

1. That the Statement of Accounts for the financial year ended 31 March 2013 be adopted and approved for submission to the Scottish Government Health Directorate. **Director of Finance**

2. That the Chief Executive be authorised to sign the Director of Finance's report, the remuneration report, the Statement of the Chief Executive's responsibilities as the Accountable Officer of the NHS Board and the Governance Statement. **Chief Executive**

3. That the Chair and the Director of Finance be authorised to sign the Statement of NHS Board Members Responsibilities in respect of the Accounts. **Chair and Director of Finance**

4. That the Chief Executive and the Director of Finance be authorised to sign the Balance Sheet. **Chief Executive and Director of Finance**

51. PROPOSED CAPITAL PLAN 2013/14 TO 2015/16

A report of the Director of Finance [Board Paper No 13/25] was submitted setting out how the NHS Board planned to deploy its allocation of capital funds for 2013/2014 noting that further discussions would be held with the SGHD during the year ahead in relation to the level of capital funding for 2014/2015 and 2015/2016.

Mr James advised that an initial capital allocation of £293.615m for NHSGGC was confirmed by SGHD in February 2013. Since this time, a further capital allocation of £374k had been awarded to NHSGGC by SGHD in respect of the Detect Cancer Early Programme. Additionally, a further amount of brokerage from 2012/13 to 2013/14, amounting to £1.3m, was agreed with the SGHD during March 2013. These adjustments resulted in a revised capital resource figure for 2013/14 of £295.289m.

Mr James led the NHS Board through the capital expenditure plan, incorporating proposed capital schemes across Acute Services (including Acute Strategy), New South Glasgow Hospitals, Health Information and Technology (HI&T), Board and Partnerships including Mental and Oral Health. Expenditure on all capital schemes would be monitored throughout the year and reported to the Joint Capital Planning and Property Group to ensure that a balanced capital position was maintained for 2013/14.

In response to a question from Councillor Rooney, Mr Calderwood confirmed that all operational parts of the organisation were pulling together their aspirations for capital investment in terms of planning for 3/5 years ahead. This would be considered in early 2014 to establish priorities within resources. Any framework would also have to understand the SGHD rules for Health Board funding going forward.

DECIDED

1. That the proposed allocation of funds for 2013/14 be approved. **Director of Finance**

2. That the current indicative allocations for 2014/15 and 2015/16 be noted.

3. That the Quality and Performance Committee and Joint Capital Planning and Property Group be delegated the authority to allocate any additional available funds against the 2013/2014 Capital Plan throughout the year. **Director of Finance**

52. 2013/14 FINANCIAL PLAN

A report of the Director of Finance (Board Paper No 13/26) was submitted providing an overview to the NHS Board of the major elements within the Financial Plan, highlighting key assumptions and risks and explaining how it was proposed to address the cost savings challenge which the NHS Board faced in order to achieve a balanced financial outturn in 2013/14.

Mr James provided an overview of the process used to develop the Plan; an explanation of the funding uplift that the NHS Board would receive in 2013/14; the most recent projection of the scale of financial challenge which the NHS Board would need to address if it was to succeed in managing its Revenue Resource Limit for 2013/14 and the cost savings plan for 2013/14 that would enable the NHS Board to address that financial challenge and deliver a break even financial outturn for the year.

Mr James took the NHS Board through the most salient points of the Financial Plan. The SGHD had confirmed a headline funding uplift for 2013/14 of £53.5m or 2.76%.

Mr James referred to the proposals for funding following discussions with Directors which had led to pressures and possible investments being captured and agreed. The 2013/14 Financial Plan assumed that the pressures and investments would be funded but Mr James erred that it might be prudent to increase the challenge in order to address additional pressures that may emerge and an update on this would be provided to the NHS Board during the year as appropriate.

In response to a question, Mr James alluded to some of the costs and pressures including pay cost growth, prescribing, energy, capital charges, inflation and the Acute Services Review. In terms of the development of a cost savings plan for 2013/14, proposals had been produced that totalled £33.7m of cash releasing savings, enabling the NHS Board to deliver a recurring balance by the end of 2013/14. Based on these plans, the NHS Board was likely to be able to retain original savings plans and to avoid increasing pressure on operational divisions. In addition, £26.2m of non-cash releasing savings would be delivered.

Mr James confirmed that the Financial Plan had been prepared using the most up-to-date information, however, it was recognised that circumstances can (and do) change during the year. As such, he highlighted some of the main risks including prescribing, winter pressures and the change to NHS boundaries. Ongoing consideration was also

being given to more material issues which would have to be considered as part of the medium term financial strategy including cross-boundary flow, the New South Glasgow Hospital, the Clinical Services Review and prescribing.

In response to a question from Councillor Rooney concerning Auto Enrolment, Mr James confirmed that, at present, a provision of £5.9m had been made for any additional costs relating to automatic enrolment of staff to the superannuation scheme. The maximum additional cost for enrolment of all staff was around £16.7m and the provision was based on around 65% of non-enrolled staff opting out. The £5.9m represented an increase of £1.3m on the previous initial estimate of £4.6m.

DECIDED

That the Financial Plan for 2013/14 be approved. **Director of Finance**

53. CORPORATE RISK REGISTER 2013

A report of the Director of Finance [Board Paper No. 13/27] asked the NHS Board to note the Corporate Risk Register 2013.

Mr James advised that the Risk Management Steering Group carried out an annual review of the Corporate Risk Register and, following discussion at the Corporate Management Team, it was submitted for approval to the Audit Committee on 4 June 2013. The Audit Scotland – Role of Boards had recommended that the Corporate Risk Register be submitted to the NHS Board.

The Board Risk Management Strategy was based on the principle that risk management arrangements were embedded within the organisation's management arrangements, supported by a hierarchy of risk registers established throughout the organisation and with an overarching corporate level Risk Register.

Members welcomed the Corporate Risk Register and the description of controls in place to manage the identified risk.

NOTED

54. UPDATED FRAUD POLICY

A report of the Director of Finance [Board Paper No 13/28] asked the NHS Board to approve the updated NHSGGC Fraud Policy which had been agreed with the Corporate Management Team (CMT), Audit Committee and Area Partnership Forum.

Mr James reported that the Board's Fraud Policy was reviewed annually by the NHS Board as part of its review of corporate governance. He referred to some minor revisions made in 2013 and explained that, following approval, the updated Fraud Policy would be incorporated in the revised Code of Conduct for staff.

DECIDED

That the updated NHSGGC Fraud Policy be approved. **Director of Finance**

55. BOUNDARY CHANGES

A report of the Chief Executive [Board Paper No 13/29] asked the NHS Board to note the proposed boundary changes and the proposed related processes.

Mr Calderwood advised that the SGHD announced its intention to revise Health Board boundaries to create consistent co-terminosity between NHS Boards and Local Authorities from April 2014. He outlined the implications of this change and the proposed process to manage it. He described how the proposed changes would fully shift responsibility for Rutherglen, Cambuslang and parts of Moodiesburn from NHSGGC to NHS Lanarkshire and, with that responsibility, the full resources to fund the services they accessed. He explained that a detailed financial and activity review was required to assess the implications for NHS Greater Glasgow and Clyde.

Mr Calderwood explained that the commitment was to ensure there was no disruption to patient services and flows. In response to a question from Mr Sime, he noted that implications for community services and staff were more limited as these had already been transferred to NHS Lanarkshire although there were a number of small services delivered into Rutherglen and Cambuslang by NHSGGC-based staff which would need to be reviewed. Furthermore, there may also be potential implications for capital assets and for the delivery of support services.

In terms of the process going forward, Mr Calderwood reported that initial discussions with NHS Lanarkshire Board officials had commenced and an agreement had been reached to establish a joint planning group to assess and manage the impact of these changes ensuring there was no disruption to patient services and that there was effective communication with local stakeholders.

In response to a question from Mr Lee, Mr Calderwood confirmed that these proposals also resulted in a small number of patients moving from NHSGGC to NHS Forth Valley and, similarly a small number of patients moving from NHS Ayrshire and Arran to NHSGGC.

NOTED

56. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer [Board Paper No 13/30] asked the NHS Board to note progress against the national targets as at the end of April 2013.

Ms Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times/18 Weeks Referral to Treatment (RRT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. She also highlighted the delayed discharge figures across NHSGGC

In response to a question from Dr Benton, Ms Grant confirmed that a number of pilots had been tested (including the use of text message reminders) in an attempt to see if "did not attend" (DNA) rates could be reduced.

In response to a question concerning the number of patients awaiting discharge in Glasgow City (where there had been an increase from April 2012 to April 2013 from 77 to 96), Mrs Hawkins agreed that this was a cause for concern and work was ongoing

with the Council's Director of Social Work and Glasgow City CHP to revamp the action plan to improve performance.

NOTED

57. QUARTERLY REPORT ON COMPLAINTS – 1 JANUARY TO 31 MARCH 2013

A report of the Nurse Director [Board Paper No 13/31] asked the NHS Board to note the quarterly report for the period 1 January to 31 March 2013 on complaints and their handling in Greater Glasgow and Clyde.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall Complaints Handling Performance of 71% of complaints responded to within 20 working days had been achieved. She alluded to the format of the report which now provided a breakdown of completed complaints by Acute Directorate then broken down further into hospital location and, in respect of CH(C)Ps, disaggregated to service areas. Further refinements would continue so that more detail was provided showing complaints per speciality/ward area together with any requirement for exception reporting to explain any anomalies or actions undertaken as a result of highlighting where specific problems may have arisen. This approach was welcomed.

In reviewing some of the service improvements as a result of complaints completed in the quarter, Ms Crocket described how this illustrated frontline actions taken to prevent a recurrence of complaint issues.

Rev Dr Shanks welcomed the new breakdown of the complaints data and the service improvements made as a result of completed complaints, the format of which illustrated how the NHS Board continued to use complaints as a mechanism to learn lessons and improve future services for patients.

NOTED

58. FREEDOM OF INFORMATION MONITORING REPORT FOR THE PERIOD 1 APRIL 2012 TO 31 MARCH 2013

A report of the Head of Board Administration [Board Paper No. 13/32] asked the NHS Board to note the annual Monitoring Report on the operation of the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004 within NHS Greater Glasgow and Clyde for the period 1 April 2012 to 31 March 2013.

Mr Hamilton reported that the overall number of FOI requests received by NHS Greater Glasgow and Clyde during 2012/13 was fairly consistent compared with the previous year, with 610 requests being received in 2012/13 compared to 614 requests received in 2011/12.

Mr Hamilton led the NHS Board through the report which detailed, amongst other issues, the source of requests, the type of information requested, performance monitoring and requests for review.

Mr Sime noted the reduction in FOI requests from members of staff and Mr Hamilton reported that this appeared to have settled down since the introduction of Agenda for

Change when many staff used the Act to request further information in relation to their Agenda for Change banding evaluation.

In response to a question from Ms Micklem, Mr Hamilton confirmed that the NHS Board's publication scheme was reviewed quarterly to ensure regular updates and revisions were made. It was acknowledged that as more information was published within the publication scheme, that fewer FOIs may be received. However, Mr Hamilton alluded to not only the large volume received but the complexity and detailed nature of the information requested.

Mr Hamilton thanked those Non-Executive NHS Board members who were involved the FOI's requirement for review process – their input was hugely appreciated.

NOTED

59. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 13/33] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED

That the 13 Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

60. AUDIT COMMITTEE MINUES: 26 MARCH 2013 AND 4 JUNE 2013

The minutes of the Audit Committee meetings held on 26 March 2013 [A(M)13/02] and 4 June 2013 [A(M)13/03] were noted.

NOTED

61. AREA CLINICAL FORUM MINUTES: 4 APRIL 2013

The Minutes of the Area Clinical Forum meeting held on 4 April 2013 [ACF(M)13/02] were noted.

NOTED

62. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 21 MAY 2013

The Minutes of the Quality and Performance Committee meeting held on 21 May 2013 [QPC(M)13/03] were noted.

NOTED

The meeting ended at 12.15pm

NHSGG&C(M)14/01
Minutes: 01 - 15

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Corporate Headquarters, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH on Tuesday, 18 February 2014 at 9:30a.m.

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Mr R Finnie
Dr C Benton MBE	Mr I Fraser
Ms M Brown	Dr M Kapasi MBE
Mr R Calderwood	Councillor A Lafferty
Dr H Cameron	Mr I Lee
Mr G Carson	Ms R Micklem
Ms R Crocket MBE	Councillor M O'Donnell (From Minute No:11)
Councillor M Cunning	Dr R Reid
Mr P Daniels OBE	Councillor M Rooney
Dr L De Caestecker	Rev Dr N Shanks
Councillor M Devlin	Mr D Sime
Prof A Dominiczak	Mr B Williamson

IN ATTENDANCE

Mr G Archibald	Lead Director, Acute Services Division
Dr E Crighton	Consultant in Public Health Medicine (For Minute No:09)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mrs A Hawkins	Director, Glasgow City CHP
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy

ACTION BY

01. APOLOGIES

Apologies for absence were intimated on behalf of Mr P James, Councillor M Macmillan, Councillor J McIlwee and Mr K Winter.

NOTED

02. DECLARATION(S) OF INTEREST(S)

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

NOTED

03. CHAIR'S REPORT

(i) On 20 December 2013, Mr Robertson visited the National Spinal Unit at the Southern General Hospital where he met with colleagues and two survivors of the Clutha helicopter tragedy.

(ii) On 17 January 2014, Mr Robertson met with the new Principal of the West of Scotland University, Professor Craig Mahoney.

(iii) On 21 January 2014, Mr Robertson attended a meeting of Glasgow Life and met its Chair, Councillor Archie Graham. This provided an excellent opportunity to better understand the wide range of services Glasgow Life delivered on behalf of Glasgow City Council for the benefit of citizens and visitors.

(iv) On 30 January 2014, Mr Robertson attended the Annual General Meeting (AGM) of Credit Union. It was also Credit Union's 15th anniversary and they now had over 8,000 members which demonstrated how appreciated the function was.

(v) On 31 January 2014, Mr Robertson and Mr Calderwood met with the Chair and newly appointed Director of the Beatson Cancer Charity.

(vi) On 5 February 2014, Mr Robertson attended the launch of the Inspiring Cancer Charity at Glasgow City Chambers.

(vii) On 13 and 14 February 2014, Mr Robertson attended the NHS Board Time-Out Session where NHS Board members heard excellent presentations that put into context the ambitious challenges and plans that lay ahead for NHSGGC from 2014/15 onwards.

(viii) Since the last NHS Board meeting in December 2013, Mr Robertson reported that various meetings had taken place of the Endowments Sub-Committee to implement the new national guidance regarding the operation and possession of public organisations' endowments funds. Work was ongoing and he anticipated a paper outlining these developments to be presented to the April 2014 NHS Board meeting. **Director of Finance**

NOTED

04. CHIEF EXECUTIVE'S UPDATE

(i) On 17 December 2013, Mr Calderwood met with the Principal of the University of Glasgow and the Cabinet Secretary for Health and Wellbeing regarding the University of Glasgow/NHS Board's imaging strategy. Mr Calderwood was delighted to announce that the Cabinet Secretary had since agreed to make a £3m contribution towards this academic centre at the new Southern General Hospital campus for imaging services.

(ii) On 30 December 2013, Mr Calderwood visited the New Lister Building on the Glasgow Royal Infirmary campus. It formally opened in January 2014 following a £15m refurbishment that included state-of-the-art equipment and facilities for staff and patients and also included two floors for the University of Glasgow.

(iii) On 6 January 2014, Mr Calderwood visited the new Southern General Hospital campus to tour the full site. He reported that significant internal works had also taken place and that the NHS Board could expect the buildings to be handed over from the contractor in January 2015. This would bring in to sharp focus how soon NHSGGC would see the realisation of this key milestone in the modernisation of Glasgow's Acute Hospital provision and the scale of the challenge that faced the NHS Board with the planned migration of services and staff into this world-class facility. The Cabinet Secretary for Health and Wellbeing had also visited the site last week and it was reported that a target of being fully operational by the end of July 2015 had been set.

(iv) On 24 January 2014, Mr Calderwood met with Jackie Baillie MSP to discuss health issues in the West Dunbartonshire area and NHSGGC's Clinical Services Review.

(v) On 29 January 2014, Mr Calderwood and Professor A Dominiczak met with representatives of Scottish Enterprise to discuss a series of issues, primarily focusing on bringing public and private monies together for the development of Research and Development facilities associated with the New South Glasgow Campus.

(vi) On 6 February 2014, Mr Calderwood attended the Scottish Enterprise Life Sciences Awards Dinner. He congratulated Professor Chris Packard, who picked up a Special Recognition Award at the prestigious event. This was for his work in demonstrating the benefits that the Life Sciences Sector could bring to Scotland.

(vii) On 11 February 2014, Mr Calderwood, Mr G Archibald and Mr P James met with colleagues from the Scottish Government Health Directorates to discuss the NHS Board's Mid-Year Review.

(viii) On 17 February 2014, Mr Calderwood and Mr P Daniels conducted interviews for the Interim/Shadow Director post for Glasgow City CHP (due to the retirement of Mrs A Hawkins from 31 March 2014). He reported that Mr A MacKenzie (currently Director, North West Sector, Glasgow CHP) had been appointed from 1 March 2014 to allow him to shadow Mrs Hawkins for one month before taking up the substantive post on 1 April 2014.

NOTED

05. MINUTES

On the motion of Mr I Fraser, seconded by Councillor M Devlin, the Minutes of the NHS Board meeting held on Tuesday, 17 December 2013 [NHSGG&C(M)13/06] were approved as an accurate record and signed by the Chair.

NOTED

06. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was noted.

(ii) In relation to Minute 110 "New Southside Hospital – Office Accommodation – Full Business Case and Community Benefit Programme", Mr Calderwood

confirmed that the Scottish Government Health Directorates had since approved the NHS Board's Full Business Case.

NOTED

07. SCOTTISH PATIENT SAFETY PROGRAMME

A report of the NHS Board's Medical Director [Board Paper No 14/01] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for mental health and the work being progressed in NHSGGC.

Dr Armstrong explained that Phase I of the mental health programme was a voluntary commitment from NHSGGC in which the NHS Board supported small scale process improvement to introduce and test the methods in mental health settings. Initially two pilot wards were committed to test one of the nationally described workstreams which related to risk assessment and safety planning.

Phase II of the programme, from October 2013 onwards, introduced mandatory expectations, and, building on the initial pilots, had seen an increase in the number of wards involved. 13 clinical teams were now participating in Phase II of the programme and the wards involved had representation from each inpatient sector in the NHS Board and included a cluster of wards on the Gartnavel Royal Hospital site.

Dr Armstrong described the five national workstreams, the first four of which related to clinical practice where the main focus would be risk assessment and safety planning. NHSGGC negotiated however, that at least one team focus on each of the four clinical workstreams so that a suitable scope of pilot work was underway. The fifth workstream, Leadership and Culture, applied to all pilots and extended to infrastructure in services such as the Staff Safety Climate tool, the Patient Safety Climate tool and Leadership Walkrounds. With regard to the mental health outcome measures, Dr Armstrong explained that a National Measurement Plan had been developed involving all participating wards to collect monthly outcome and balancing measures that were submitted to Health Improvement Scotland (HIS). A year's worth of retrospective data was also collected. She summarised the outcome measures and reported that work was underway to improve the reliability of the data with the new teams with a timescale to begin to submit data to the national team in February/March 2014. Furthermore, a quarterly progress report was being produced for HIS to include a summary of ongoing tests of change and accompanying data that was shared through the Knowledge Network site. HIS had visited NHSGGC on 13 December 2013, the purpose of which was to obtain an overview on Phase II of the programme and to discuss progress made. Areas were highlighted that were strengths and also areas for development for the delivery of the programme. HIS had agreed to fund and support the second local learning session in March 2014.

Dr Armstrong emphasised the importance in learning sessions – both at local and national level and confirmed that, so far, two *local* learning sessions had taken place and four *national* learning sessions.

Councillor Rooney asked about one of the mental health outcome measures "days between inpatient suicide". Dr Armstrong reported that this would result in a Significant Incident with a full team set up to investigate the circumstances thoroughly.

Mr Fraser also asked about the mental health outcome measures and Dr Armstrong explained that these were nationally-determined and agreed that, as the programme was in its infancy, there may be other outcomes collected and measured in the future.

Mrs Hawkins agreed with this point, explaining that, as SPSP in mental health services

became more established, outcome measures could be added.

Mr Williamson referred to an outcome measure in palliative care which looked at quality of life and suggested that it may be adapted for mental health. Mrs Hawkins thanked Mr Williamson for the suggestion and agreed that this would be fed back to the national team to reflect on. **Medical Director**

NOTED

08. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/02] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. This target was extended once again, and NHS Boards were required to achieve a rate of 26 cases per 100,000 Acute Occupied Bed Days (AOBDs) by April 2013. For the last available reporting quarter (July to September 2013), NHSGGC reported 36.8 cases per 100,000 AOBDs. NHS Scotland reported 31.4 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to now achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, July to September 2013, NHSGGC reported 34.1 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 41.6 per 100,000 AOBDs.

For the last available quarter (July to September 2013), the surgical site infection (SSI) rate for hip anthroplasty procedures remained below the national average, repair of neck and femur procedures matched the national rate of 2.1%, while the SSI rate for knee anthroplasty and caesarean section procedures were above the national average although both remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,003 members of staff who were now registered as Cleanliness Champions.

With regard to the increase in reported SAB cases, Dr Armstrong alluded to some of the possible contributors to this and the actions being taken by NHSGGC clinical and infection control teams to address this. She highlighted, in particular, enhanced surveillance and reporting and emphasised that sustaining a reduction in cases (which were amenable to improvement) required the continued support of all clinical staff within the Acute Directorates to ensure that optimal practice was applied in the

procedures which required an aseptic technique.

Dr Armstrong explained that the enhanced surveillance included a clinical review on each hospital acquired case and community onset healthcare associated case that was linked to a clinical specialty or had a feature that was amenable to improvement. Councillor Rooney asked if this included care homes and Dr Armstrong responded in the affirmative.

NOTED

09. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT – 1 APRIL 2012 TO 31 MARCH 2013

A report of the Director of Public Health [Board Paper No. 14/03] asked the NHS Board to note the Public Health Screening Programme Annual Report from 1 April 2012 to 31 March 2013.

Dr De Caestecker presented information about the following screening programmes offered to residents across NHSGGC for the period 2012/13:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
  - Communicable diseases in pregnancy
  - Haemoglobin apothics in screening
  - Downs syndrome and other congenital anomalies
- New born screening:-
  - New born blood spot
  - Universal new born hearing
- Diabetic retinopathy screening
- Preschool vision screening
- Interim report in aortic abdominal aneurysm screening

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions.

In NHSGGC, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit led by a consultant in public health medicine. Multi Disciplinary Steering Groups for the programmes were in place and the remit was to monitor performance, uptake and quality assurance.

Dr Crighton highlighted that, as the screening programmes stretched across the whole organisation, successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. It was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered to NHSGGC residents. All the screening programmes, with the exception of preschool vision screening, had clinical standards set by Health Improvement Scotland. Dr Crighton explained, however, that reporting structures for Scottish Public Health Screening programmes were currently under review and she led the NHS Board through the proposed governance arrangements; comparing these with the current governance arrangements in NHSGGC.

NHSGGC's Public Health Screening Unit was committed to working in partnership

with voluntary and statutory services to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes. For the second year, the report also included analysis on uptake among people with learning disabilities but Dr Crighton reported that screening activity by ethnicity could not, as yet, be provided as this data was not available.

Dr De Caestecker commended the efficiency of the screening programmes and reiterated that they could prevent disease. She and Dr Crighton responded to a range of members' questions by confirming the following:-

- Posters and advertisement cards had been circulated that would be used for a pilot in Glasgow North West to increase the uptake rates for cervical screening in the 21-35 year old age group. It would be launched at the beginning of March 2014 and the key message was to allay any fear and/or embarrassment about cervical screening.

- The overall uptake across NHSGGC for the first dose of the HPV vaccination was 94.6% and 93.1% for the second dose. This was above the Scottish average, however, uptake for the third dose was 78.8% which was below the Scottish average. Dr Crighton agreed that this was disappointing and alluded to a poorer uptake of the vaccination in areas of deprivation. As such, work was ongoing to address the barriers to low uptake and, in particular, a lot of work was being undertaken with looked-after children.

- General uptake rates and addressing inequalities was a priority in order to close the inequality gap. This was a major concern and campaigns were now being designed and developed with particular target groups/age groups in mind. Dr De Caestecker cited the example of visual screening which was undertaken in nurseries but, in doing so, missed children who may not attend a nursery. That patient group often did not attend clinic/hospital appointments either and work was ongoing to enhance family support with Primary Care Development workers becoming involved with families.

- Abdominal aortic aneurysm screening was implemented in February 2013 and male residents aged 65 in NHSGGC would be invited to participate in this screening programme. Based on evidence, one scan was sufficient and this was the best way to detect the presence of an abdominal aortic aneurysm. Based on research, no evidence was apparent, at the moment, to suggest further screening thereafter. Dr Crighton reported that males over 65 years of age could self-refer and, although not widely publicised just now, a communications strategy was now in place to address this. To date, these men tended to find out by word-of-mouth.

- Breast screening audit reporting would be available late in March 2014. From the data available, Dr Crighton advised that, in NHSGGC compared to that for Scotland, breast cancer incidence rates were lower but deaths from breast cancer were higher. To capitalise on the planned national Detect Cancer Early (DCE) social marketing campaign of 2013, NHSGGC had developed a local social marketing campaign to reinforce the DCE breast cancer messages and encourage women to take up breast screening.

- The wealth of information was welcomed and engaging the support of celebrities to boost uptake in the screening programmes was raised. Dr Crighton alluded to some celebrities being used at a *national* level as celebrities did have pulling power if they were relevant to particular age groups.

- In relation to the bowel screening programme and improving the uptake rate

for those with learning disabilities, Dr Crighton agreed that this particular uptake rate was very poor and, historically, this group of patients had been difficult to engage with in the past. Given that, good engaging materials were being pulled together and a more proactive approach would be taken to communicate/engage with that group of patients and/or their carers.

Mr Robertson, on behalf of the NHS Board, thanked Dr De Caestecker and Dr Crighton for their comprehensive summary of the Annual Report.

NOTED

10. HEALTH AND SOCIAL CARE INTEGRATION:- GLASGOW CITY AND EAST DUNBARTONSHIRE

A report of the Director of Corporate Planning and Policy [Board Paper No 14/04] asked the NHS Board to note progress to move to Shadow Health and Social Care Partnerships with Glasgow City Council and East Dunbartonshire Council.

Ms Renfrew apologised for circulating the paper so late but explained that this had been due to the respective Councils approving the arrangements. That had now been completed and she explained that agreement had been reached to establish a Body Corporate Model Partnership as follows:-

- Glasgow City – covering all health and social care services. Furthermore, as Mr Calderwood referred earlier, arrangements had been made in that Mr A MacKenzie had been appointed Interim Director of Glasgow CHP and an Integration agreement was being drafted which would come to the NHS Board and Council for approval and would provide the basis of operation for the Partnership in its shadow year. **Director of Corporate Planning & Policy**

- East Dunbartonshire – covering adult health and social care services. Furthermore, Karen Murray, currently CHP Director, had been appointed as Shadow/Interim Chief Officer to lead the development of the new Partnership. A shadow integration agreement was being drafted which would come to the NHS Board and Council for approval and would provide the basis of operation for the Partnership in its shadow year. **Director of Corporate Planning & Policy**

NOTED

11. WAITING TIMES AND ACCESS TARGETS

A report of the Lead Director, Acute Services Division [Board Paper No 14/05] asked the NHS Board to note progress against the national targets as at the end of December 2013.

Mr Archibald led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times/18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Mr Williamson commended continued performance in linked pathways (a measure of the percentage of patients where their total pathway was being linked). NHSGGC continued to exceed the target of 80%. In paying tribute to the Acute Division's teams in achieving this, he wondered if it was now timely to suggest increasing the target.

Mr Archibald noted that there was significant complexity involved in improving performance for this indicator, due in part to NHSGGC's status as a tertiary service provider for other NHS Boards and the cross-boundary referrals that occurred. Work, however, continued nationally to develop more robust inter-board processes to allow appropriate pathway linkages to be facilitated.

Councillor Lafferty welcomed the comprehensive information provided in the report on Accident and Emergency waiting times. In response to his question, Mr Archibald observed that different pressures occurred at different A&E hospital locations and he described that this was mainly due to the demography and morbidity being different for each hospital which resulted in admission levels/attendances differing.

Ms Micklem noted that, nationally, inpatient/day case spinal surgery had been excluded from the 12 week treatment time guarantee (TTG) and that there were a number of patients in this category within NHSGGC. She wondered if there were any other exclusions from the 12 week TTG. Mr Archibald confirmed that was the only exclusion albeit that, locally, the Institute of Neurosciences Management and clinical teams continued work to bring such services within 12 weeks.

NOTED

12. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2013

A report of the Director of Finance [Board Paper No 14/06] asked the NHS Board to note the financial performance for the first nine months of the financial year.

Mr Calderwood explained that the NHS Board was currently reporting a surplus of £5m for the first nine months of the year. At this stage, therefore, the NHS Board was forecasting that a year-end surplus of £8m would be achieved. Mr Calderwood led the NHS Board through further information in relation to expenditure in Acute Services, NHS Partnerships and Corporate Services, and included details of expenditure to date against the NHS Board's 2013/14 Capital Plan.

Mr Calderwood also reported that the month ten figure suggested a surplus of £7.1m.

Mr Finnie wondered if there was any way to relate operational activity to financial reporting as, given discussions earlier concerning pressures on operational teams, he thought it would be useful to see this reflected in the financial monitoring reports. Mr Calderwood agreed that it would be useful to see the financial monitoring report form a core relationship with the other NHS Board papers and mused on how accounts could be described and illustrated in a more helpful way. He agreed to discuss this further with Mr James.

Director of Finance

Councillor Rooney asked about the arrangements for transition to the New Southern General Hospital. Mr Calderwood reported that £8m had been set aside for this and outlined some examples for the migration which included:-

- From late January 2015 onwards, the need to employ around 250 people to deal with the commissioning of the new hospital;
- Staff being released for induction training and for familiarisation purposes at the new hospital (and their associated backfill for their shifts at the Victoria Infirmary, existing Southern General Hospital, Western Infirmary and Royal Hospital for Sick Children);
- Double running costs for a short period of time at the sites;
- From Spring 2015 onwards, release costs from the Victoria Infirmary, Western Infirmary, Southern General Hospital and Royal Hospital for Sick Children;

- Decommissioning of these sites which would lead to their vacation and onward disposal.

In response to a further question from Councillor Rooney concerning future capital available for any potential new medical centre for Clydebank, Mrs Hawkins explained that the NHS Board had drawn up a list of major refurbishment (and/or replacement) proposals so that a feasibility study could be undertaken. This would be completed by the end of March 2014 when it could then be reprioritised for consideration by the NHS Board. She did explain however, that supporting the revenue in any new capital investment would be a challenge and described how the Scottish Government Health Directorates Hub funding operated and it was anticipated that business cases would be pulled together once the priorities had been considered so that bidding for Hub funding could be undertaken.

NOTED

13. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 14/07] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED

That the two Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

14. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 21 JANUARY 2014

The Minutes of the Quality and Performance Committee meeting held on 21 January 2014 [QPC(M)14/01] were noted.

NOTED

15. ANY OTHER COMPETENT BUSINESS

Retiral of Mrs A Hawkins – Mr Robertson reported that this would be the last meeting of Mrs Hawkins prior to her retiral. She had worked in the NHS for over 20 years (including a period in NHS Forth Valley). She had led NHSGGC's integration with "Clyde", providing guidance and leadership to the Mental Health Partnership and, latterly, led Glasgow CHP. She would be greatly missed and, on behalf of the NHS Board, he extended his tremendous appreciation of the work she had done. Mrs Hawkins thanked Mr Robertson and NHS Board members for their kind remarks and wished the NHS Board luck in the future.

NOTED

The meeting ended at 11.40am

NHSGG&C(M)14/02
Minutes: 16 - 35

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Corporate Headquarters, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH on Tuesday, 15 April 2014 at 9:30a.m.

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Councillor A Lafferty
Dr C Benton MBE	Mr I Lee
Ms M Brown	Councillor M MacMillan
Dr H Cameron	Councillor J McIlwee
Ms R Crocket MBE	Ms R Micklem
Councillor M Cunning	Councillor M O'Donnell
Councillor M Devlin	Dr R Reid
Prof A Dominiczak	Councillor M Rooney
Mr R Finnie	Rev Dr N Shanks
Mr P James	Mr D Sime
Dr M Kapasi MBE	Mr B Williamson

Mr K Winter

IN ATTENDANCE

Mr J Best	Director, Regional Services
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr B Moore	Director, Inverclyde CHP (Representing Partnership Directors)
Mr A McLaws	Director of Corporate Communications
Dr G Penrice	Consultant in Public Health Medicine (For Minute No: 24)
Ms J Reid	Immunisation Programme Manger (For Minute No: 24)
Ms C Renfrew	Director of Corporate Planning and Policy
Dr A Stanley	Consultant in Gastroenterology (For Minute No: 16)

ACTION BY

16. PRESENTANTION ON MALAWI

Before beginning the formal NHS Board meeting, Mr Robertson introduced Dr A Stanley, Consultant in Gastroenterology. Dr Stanley attended the NHS Board meeting on 19 February 2013 to outline the support given to Malawi from the NHS at large but, in particular, from NHSGGC. He thanked the NHS Board for the invitation to provide an update on developments since last year and outlined how endoscopic services were being developed and supported in three central hospital endoscopy units in Blantyre, Lilongwe and Mzuzu. Following the provision of some equipment from NHSGGC, the main aims were to teach local clinicians the necessary skills in band ligation and stent insertion and this was undertaken by onsite training visits and formal UK approved endoscopy training courses in Malawi and progressed with regular meetings with hospital directors.

Prior to his training visit in October 2013, Dr Stanley reported that three video endoscopes, monitors, cables, accessory equipment and computers were shipped out via Glasgow City Council. On his arrival, the computer was installed for electronic reporting and presentations and guidelines duly uploaded. In terms of going forward, Dr Stanley reported that further training was scheduled for April 2014 and October 2014 and he was hopeful that further equipment would be sourced for further development and training purposes. He thanked NHSGGC for donating the endoscopes and other equipment and Glasgow City Council for shipping this from Glasgow to Malawi.

Mr Williamson commended the project and acknowledged its benefits to local communities and the trainees who undertook the courses. In response to his question, Dr Stanley confirmed that four courses had been held, to date, and eight local Malawi clinicians had attended each course. He acknowledged that many endoscopy procedures were undertaken by nurses in western countries but reported that this was not the case yet in Malawi – the focus was on surgeons and clinical medical officers undertaking this role. He reported that some staff had come from Malawi to Glasgow, where funding had been obtained, to learn techniques with the intention of returning to Malawi and adapting their training to the facilities and services available there.

Professor Dominiczak highlighted that the University of Glasgow had joined the Malawi-Liverpool Welcome Trust and alluded to opportunities for future collaborative working. Furthermore, some education programmes were being undertaken by the University of Glasgow and Professor Dominiczak suggested that Dr Stanley make contact with relevant personnel.

Mr Robertson reiterated the importance of maximising the use of equipment that may become redundant in NHSGGC when the new South Glasgow Hospitals opened. Mr Best confirmed that NHSGGC's procurement team was cited on this.

Mr Robertson thanked Dr Stanley for the informative presentation and update.

NOTED

17. APOLOGIES

Apologies for absence were intimated on behalf of Mr R Calderwood, Mr G Carson, Mr P Daniels OBE, Dr L De Caestecker and Mr I Fraser.

NOTED

18. DECLARATION(S) OF INTEREST(S)

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

NOTED

19. CHAIR'S REPORT

(i) On 20 February 2014, Mr Robertson met with the Committee of the Samaritan Society at the Western Infirmary. The Society originally provided financial support for patients and their families in need before the days of welfare

benefits. As they would shortly be winding up their services after over 30 years, Mr Robertson regarded it as important to give recognition to the work they had done throughout the years.

(ii) On 14 and 21 March 2014, Mr Robertson, along with other Non-Executive NHS Board members, visited the New South Glasgow Hospitals. He had been hugely impressed with the progress made and reported that many parts of the buildings were complete and now awaiting delivery of equipment. The handover date would be the end of January 2015 and the project remained within budget. Attention was now being focussed on the development of migration plans for the Victoria Infirmary, Western Infirmary, Royal Hospital for Sick Children, Mansionhouse Unit and older parts of the Southern General Hospital. This was a huge undertaking and the contractor, Brookfield Multiplex, had recently handed over a comparable hospital in Western Australia. Mr Calderwood and an operational team were currently with Brookfield Multiplex visiting Western Australia Health Authorities to discuss their handover arrangements and technical details and this was proving very useful.

(iii) On 20 March 2014, Mr Robertson met with COSLA in Edinburgh where discussion focused on the governance and delivery of the new Health and Social Care Partnerships. Although in NHSGGC, energies were being spent on getting the six new Partnerships up and running, it was important to also be able to contribute to central policy discussions.

(iv) On 24 March 2014, Mr Robertson attended Glasgow City Chambers for the Addiction graduation ceremony. This celebrated SVQ awards and other certificates given to individuals supported by addictions teams and was an excellent event for them and their families.

(v) On 29 and 31 March 2014, Mr Robertson attended events in St Andrews Cathedral, the City Chambers and Kelvingrove Art Gallery and Museum to commemorate those who had lost their lives (and others who survived) in the Clutha Helicopter Tragedy. The events also highlighted the appreciation of the combined efforts of all the emergency services and the NHS was well represented and given a real sense of appreciation.

NOTED

20. MINUTES

On the motion of Mr D Sime, seconded by Professor A Dominczak, the Minutes of the NHS Board meeting held on Tuesday, 18 February 2014 [NHSGG&C(M)14/01] were approved as an accurate record and signed by the Chair pending the following addition:-

- Page 7, Item 09 "Public Health Screening Programmes Annual Report – 1 April 2012 to 31 March 2013", 5th bullet point, add "Mrs Brown asked if there was any significance in the comparatively lower incidence rates (but higher death rates) in NHSGGC and Dr De Caestecker confirmed there was no known significance".

NOTED

21. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was noted.

(ii) Councillor Rooney questioned why none of the actions in relation to Minute No: 09 (Public Health Screening Programmes Annual Report – 1 April 2012 to 31 March 2013) were noted in the Rolling Action List to ensure actions were taken to improve performance. Mr Hamilton reported that this was an omission and would be duly added to the Rolling Action List. **Head of Board Administration**

(iii) In respect of the handling of endowments funds as discussed at the 18 February 2014 NHS Board Meeting, under Minute No: 3 (Chair's Report), Mr Robertson reported that a strategy was being compiled and would be complete in July 2014 – the NHS Board would, thereafter, receive this for consideration. **Director of Finance**

NOTED

22. SCOTTISH PATIENT SAFETY PROGRAMME

A report of the NHS Board's Medical Director [Board Paper No 14/08] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for primary care and the work being progressed in NHSGGC.

Dr Armstrong reminded the NHS Board that the Scottish Government formally launched the SPSP Primary Care programme in April 2013 with the overall aim "to reduce the number of patient safety incidents to people from healthcare delivered in any Primary Care setting. All NHS territorial Boards and 95% of Primary Care clinical teams would be developing their safety culture and achieving reliability in three high risk areas by 2016".

She reported that NHSGGC commenced, in 2011, with a locally established programme involving eleven general practices and six district nursing teams testing on the following clinical processes:-

- Medicines reconciliation;
- Disease modifying anti-rheumatic drugs (DMARDs);
- Prevention of pressure ulcers in the community (district nurses).

The local initiative had now evolved into the National Programme and had been extended to include 21 practices and eight district nursing teams. An additional district nursing team had been identified to take forward improvement aims relating to nutritional screening and falls prevention. In addition, an NHSGGC polypharmacy local enhanced service had been developed addressing polypharmacy and the quality, safe and effective use of long-term medication. A medicines reconciliation component had been built into this local enhanced service and 252 practices participated, so far, in NHSGGC.

Dr Armstrong led the NHS Board through detail of the actions being taken to progress all of the workstreams in the programme. She explained that the lack of a SPSP data system meant that a great deal of effort went into manual data collection and collating data from different systems. This continued to prove challenging, limiting further expansion of the programme and had repeatedly been highlighted to the National Support Team in Healthcare Improvement Scotland.

Ms Crocket highlighted some of the work being undertaken in Community Nursing with areas identified for improvement to patient safety which included falls, catheter acquired urinary tract infections, malnutrition universal screening tool and the continuation of the prevention of pressure ulcer work. Work had commenced with district nurses to develop each of these workstreams and test the prototypes to develop reliable models of care that could be spread across the system. To date, work had focused on pressure ulcers and the malnutrition universal screening tool.

Mr Williamson regarded the report to be very enlightening and commended the excellent developments in Primary Care. In terms of the work being undertaken by Community Nursing, he wondered how this was governed. Ms Crocket alluded to the support from Professional Nurse Advisors, GPs and Partnership Clinical Directors for the work being undertaken by District Nurses, which was fed into Partnerships' Clinical Governance Forums and Professional Nurse Groups.

Councillor Rooney regarded the uptake from NHSGGC's Primary Care practitioners to be very encouraging so far, and hoped this would continue to meet the target by 2016. He asked about the incidences of pressure ulcers in patients from residential care homes. Ms Crocket reported that any patient with a pressure ulcer could be tracked to identify exactly where it originated. On a monthly basis, information was fed back through Heads of Nursing and Partnerships to identify and prevent reoccurrence and this method of monitoring was proving really helpful for district nurses.

In response to a question from a member, Dr Armstrong confirmed that a support infrastructure needed to be built up and the current funding of clinical posts was from National QUEST monies. Ms Micklem followed this up by asking about progress being made by Healthcare Improvement Scotland to obtain a data collection system. Dr Armstrong reported that discussions were ongoing on how best to collect data nationally. At the moment, however, this was being collected manually and presented a challenge. Mr Wright (Director of Health Information and Technology, NHSGGC) was also involved in the discussion, looking at whether any use could be made of the Clinical Portal to help with this.

Councillor O'Donnell wondered whether, as integration developed, there was scope for Local Authority employees (particularly Social Work) to supplement/complement the work of district nursing. Ms Crocket thought there were huge opportunities for development and the roll-out of good practice as the Integrated Partnerships bedded in.

In response to a question from Dr Benton, Ms Crocket confirmed that the Tissue Viability Specialist Nursing Team worked with district nurses providing support and advice.

NOTED

23. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/09] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. This target was extended once again, and NHS Boards were required to achieve a rate of 26 cases per 100,000 Acute Occupied Bed Days (AOBDs) by April 2013. For the last available reporting quarter (October to December 2013), NHSGGC reported 36.8 cases per 100,000 AOBDs. NHS Scotland reported 33.4 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to now achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, October to December 2013, NHSGGC reported 31.9 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 32.9 per 100,000 AOBDs.

For the last available quarter (October to December 2013), caesarean section procedures were below the national average, hip anthroplasty procedures matched the national average of 0.7% while the surgical site infection (SSI) rate for knee anthroplasty and repair of neck femur procedures rose above the national average although both remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,041 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong alluded to some of the actions being taken by NHSGGC's clinical and infection control teams to achieve the SAB HEAT target of 24 cases or less per 100,000 AOBDs by 31 March 2015 and referred, in particular, to monitoring which included each Acute Directorate having illustrative reductions updated each quarter to monitor progress towards this target.

Ms Crocket alluded to the two Healthcare Environment Inspectorate (HEI) unannounced inspections at the Victoria Infirmary (on 27 November 2013) and the Vale of Leven Hospital (on 16 January 2014). She led the NHS Board through the requirements and recommendations made as a result of these two inspections.

In response to a question from Councillor Rooney regarding the SAB performance, Dr Armstrong explained that although the October to December 2013 performance was 36.8 cases per 100,000 AOBDs, she had been informed that the January to March 2014 performance was 26.7 – she was confident, therefore, that NHSGGC would be able to achieve the rate of 24 cases by March 2015. With regard to the calculation of bed days used for the C.Diff infection in patients aged 65 and over, she responded by reporting that this had now been corrected nationally as the original calculation had been set incorrectly.

Dr Benton referred to the exception report regarding Ward 2, Leverndale Hospital, which had been closed to admissions and transfers on 7 February 2014 due to five confirmed cases of influenza A. She wondered if there was any link with staff in relation to these cases and whether or not staff in the Ward had been immunised. Dr Armstrong agreed to obtain more details about this and let Dr Benton know.

Medical Director

NOTED

24. REVIEW OF STAFF FLU VACCINATION PROGRAMME 2013/14 IN NHSGGC

A report of the Director of Public Health [Board Paper No 14/10] asked the NHS Board to note the Review of Staff Flu Vaccination Programme 2013/14 in NHSGGC.

Dr Penrice reported that the Staff Flu Vaccination Programme had been running for several years in Scotland and in NHSGGC. Historically, the uptake of the vaccine had been very low, varying from 15% to 20%. Since 2010/11 therefore, the Public Health Protection Unit had worked closely with NHSGGC's Occupational Health Service and other key stakeholders to deliver the Annual Staff Flu Vaccination Programme. In 2010/11, the uptake among NHSGGC staff was approximately 24%, improving to 36% in 2012/13. Uptake for 2013/14 was 32% and this had, as per previous years, included four modes of vaccination delivery to NHSGGC staff including peer immunisation, mass staff vaccination clinics, roving teams and appointments at the Occupational Health Department. Furthermore, a communication strategy was used to raise awareness amongst staff of how to access the flu vaccination and challenged the myths surrounding it.

Given the disappointing uptake, NHSGGC's Multidisciplinary Planning Group had been reconvened to learn lessons from 2013/14 and begin planning for 2014/15. The Planning Group had, to date, identified a number of priority areas to consider including:-

- Representation from the Acute Services Division on the Planning Group to facilitate more effective engagement and targeting of clinical/medical staff;
- Consult with staff regarding motivations for, and barriers to, flu vaccination using Survey Monkey questionnaires;
- Review and refresh the communications strategy including weekly "myth-busting";
- Evaluate and strengthen the role of Flu Champions;
- Ensure data was recorded consistently each year to enhance applicability of analysis and reduce time screening data including location of peer immunisation sessions;
- Further promote peer immunisation as an accessible method for NHSGGC's clinical/medical staff to receive the vaccine and encourage return of forms;
- Investigate potential learning from NHS Boards with higher uptakes.

Mr Sime agreed that staff needed to be encouraged more to get the flu vaccination however, cautioned that not all 39,000 members of staff were in patient-facing roles so the result may not be as bad as it appeared.

Mr Winter agreed, however, thought it would be useful to identify staff who had (and had not) had the vaccination so that a more persuasive approach could be taken with those who had not.

Mr Finnie supported the idea of obtaining staff views but wondered if there was a more rigorous undertaking that could be carried out rather than consulting them via a questionnaire concerning their motivations for/against having the vaccination. Mrs Brown agreed that staff had a right to choose but also considered that staff had a responsibility to their job and the patients they treated and, given this, the results were particularly disappointing despite all the work that had been done to encourage staff to have the vaccination. She also asked if Appendix 1 which showed the uptake of the flu vaccination at various locations throughout NHSGGC, week on week, could have an additional column added to be able to compare like for like performance across the sites – Dr Penrice acknowledged that this could be added in future reports.

Director of Public Health

Dr Reid asked why staff having the flu vaccination was voluntary rather than mandatory and wondered if this was because the evidence was not strong enough to make it mandatory? Dr Penrice responded that it was national policy. Mr Williamson agreed and suggested that, given the strength of feeling amongst NHS Board Members regarding the disappointing results, this form further discussion with Dr de Caestecker at a future NHS Board Seminar. Mr Robertson welcomed this suggestion and agreed that it would be factored into the Seminar Rolling Programme.

Director of Corporate Planning and Policy

Dr Kapasi suggested correlating staff sickness/absence from work due to the flu versus staff members who did not get the vaccination – this may be a useful way of highlighting the importance to staff of the flu vaccination.

Ms Reid explained that a staff questionnaire had been circulated to staff in an effort to find out what motivated staff to be vaccinated, what were barriers for others and what could be done to encourage more staff to take up the offer. Approximately 4,000 responses had been gathered. She went on to say that more targeted focus groups/semi-structured interviews were being planned for areas that had achieved a better uptake and those that had not performed as well. Ms Reid assured NHS Board members that planning for this year's staff flu vaccination programme would be informed by the findings.

NOTED

25. EAST DUNBARTONSHIRE HEALTH AND SOCIAL CARE SHADOW HEALTH AND SOCIAL CARE PARTNERSHIP AGREEMENT

A report of the Director of Corporate Planning and Policy and Interim Chief Officer, East Dunbartonshire CHP [Board Paper No 14/11] asked the NHS Board to approve the Partnership Agreement as the basis to establish a Shadow Integrated Joint Board (IJB) with East Dunbartonshire Council.

Ms Renfrew described the proposed local arrangements for the transition to a Shadow Health and Social Care Partnership for the East Dunbartonshire Council area in preparation for the enactment of the Public Bodies (Joint Working) (Scotland) Act 2014. She set out the arrangements for NHSGGC and the Council to work in partnership to establish a shadow IJB and then to a full IJB when the legislation required was fully in place. She described the first stage which was to establish a shadow IJB to lead, with the Interim Chief Officer, planning for the transition to the new Partnership. At this stage, the shadow IJB would operate alongside the current NHSGGC and Council governance arrangements operated by the CHP and Social Work Committee respectively.

Mr Sime welcomed the involvement of the Public Partnership Forum's input to take account of both health and social care service users. He also encouraged the development of mechanisms to achieve meaningful engagement with NHS and Local Authority Trade Unions and Professional Organisations, over the shadow period, in order to fully meet NHS Staff Governance standards and the Council's Partnership At Work arrangements.

In response to a question from Dr Reid, Ms Renfrew confirmed that, in accordance with the Act, the Chief Officer of the Shadow IJB was a non-voting member.

Councillor Lafferty asked about the chairing arrangements to be made for the IJBs and Ms Renfrew confirmed that these would be locally negotiated from 1 April 2015 onwards and confirmed that the role of Chair had the casting vote on the IJBs.

DECIDED

- That, the Partnership Agreement as the basis to establish a Shadow Integration Joint Board with East Dunbartonshire Council, be approved.

Director of Corporate Planning and Policy

26. WAITING TIMES AND ACCESS TARGETS

A report of the Lead Director, Acute Services Division [Board Paper No 14/12] asked the NHS Board to note progress against the national targets as at the end of February 2014.

Mr Best led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times - 18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

In response to a question from Dr Shanks concerning Accident & Emergency (A&E) waiting times performance at the Western Infirmary, Mr Best provided reassurance that actions were being taken to address this challenge including looking at patient flows and services to ensure that patients were discharged as soon as they were ready including ensuring prescriptions were written in advance and travel arrangements (including ongoing discussions with the Scottish Ambulance Service) were made. In response to a further question from Mr Sime concerning A&E waiting times, Mr Best reported that the SGHD looked at overall NHSGGC performance but also that of each hospital site.

With regard to patients awaiting discharge, Mr Best reported that, from April 2015, the national target for discharge would be two weeks. Given this, joint planning work continued with Local Authorities regarding older people and was supported by the additional "Change Funds" released to Partnerships. As at the end of February 2014, the areas with significant numbers of delays were Glasgow City (South Glasgow) and South Lanarkshire and funding was now being flagged as a barrier to discharge. Councillor Cunning noted that there had been local management difficulties in this regard which were hopefully now resolved and a paper was being presented for consideration by Glasgow City Executive Group to take this forward. Ms Renfrew outlined the actions being taken to address this including weekly meetings focusing on delays and issues with allocation as well as the increase in the use of "step down beds" with 35 places now available across the city with current occupancy at 80%.

Mr Williamson noted cancer waiting times and, in particular, the three screened cancers (breast, cervical and colorectal). In response to his question about the

difference in performance between screened only and screened excluded for colorectal, Mr Best reported that a detailed action plan was in place that had a commitment to address this imbalance.

In response to a question from Dr Cameron, Mr Best confirmed that "linked pathways" referred only to consultant episodes.

NOTED

27. FINANCIAL MONITORING REPORT FOR THE 11 MONTH PERIOD TO 28 FEBRUARY 2014

A report of the Director of Finance [Board Paper No 14/13] asked the NHS Board to note the financial performance for the first eleven months of the financial year.

Mr James explained that the NHS Board was currently reporting a surplus of £9.7m for the first eleven months of the year. At this stage, therefore, the NHS Board was forecasting that a year-end surplus of £10m would be achieved. Mr James led the NHS Board through further information in relation to expenditure in Acute Services, NHS Partnerships and Corporate Services, and included details of expenditure to date against the NHS Board's 2013/14 Capital Plan.

In response to a question from Councillor Rooney concerning the £10m surplus, Mr James confirmed that this was non-recurring money which had been reported to the NHS Board's Quality and Performance Committee and would be used to assist with the transition costs of the move to the New South Glasgow Hospitals – he confirmed that this arrangement had been agreed with the SGHD. In response to a further question from Councillor Rooney regarding the brokerage agreement with the SGHD of £7m of Capital Funding which had been returned by the end of February 2014, Mr James explained the process for this in that the NHS Board would get this back in 2014/15.

Mrs Brown referred to the earlier discussion around the £10m surplus and understood the logic for this being used for the double-running costs as migration progressed to the New South Glasgow Hospitals. She asked whether there would be opportunities to use these monies for any other purpose and Mr James reported that a report would be presented to the May 2014 Quality and Performance Committee meeting scrutinising, in further detail, the savings plan for recurring and non-recurring expenditure and to identify exactly how it would be used.

NOTED

28. PATIENTS' PRIVATE FUNDS – ANNUAL ACCOUNTS 2012/13

A report of the Director of Finance [Board Paper No 14/14] asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorates, the 2012/13 Patients Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

Mr James advised that the NHS Board held the private funds of many of its patients, especially those who were in long term residence and who would have no ready alternative for the safe-keeping and management of their funds. Each of the Board's hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service. Any funds that were not required for immediate use were invested to generate interest which was then

distributed to the patients' accounts based on each individual's balance of funds held

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

In terms of process, Mr James suggested that these funds, in future, be approved by the NHS Board's Audit Committee rather than being considered by the NHS Board. This was agreed. **Director of Finance**

Councillor Cunning was interested in the governance of the arrangements surrounding the management of these funds and Mr James confirmed that this was covered in the legislation including the process to deposit/withdraw from accounts which was done at a cashier's office on each NHS hospital site. Nonetheless, he suggested further discussion at a future Board Seminar to go into more detail around how this was managed. Councillor Cunning welcomed this suggestion. **Director of Corporate Planning and Policy**

DECIDED

1. That the Patients' Private Funds Annual Accounts for 2012/13 be adopted and approved for submission to the Scottish Government Health Directorates. **Director of Finance**

2. That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2012/13. **Director of Finance/Chief Executive**

3. That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2012/13. **Chair/Director of Finance**

4. That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board. **Chief Executive**

29. QUARTERLY REPORT ON COMPLAINTS: 1 OCTOBER – 31 DECEMBER 2013

A report of the Nurse Director [Board Paper No 14/15] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 October to 31 December 2013.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints-handling performance of 80% of complaints responded to within 20 working days had been achieved.

Ms Crocket alluded to the three issues attracting most complaints and highlighted that, across Partnerships and the Acute Division, these were disappointingly, the same, namely, clinical treatment, date for appointment and attitude/behaviour. These issues were consistent with previous quarters and she outlined some of the service improvements and actions being taken in an attempt to address this and improve complaints handling across NHSGGC.

In terms of investigation reports/decision letters published by the Scottish Public Services Ombudsman during the reporting quarter, Ms Crocket was pleased to report

that more issues had not been upheld than upheld and this represented an improvement. All upheld issues highlighted by the Scottish Public Services Ombudsman were scrutinised by the Quality and Performance Committee and operational directors to identify lessons learned to avoid a recurrence.

In response to a question from Councillor O'Donnell, Ms Crocket confirmed that Glasgow City CHP "hosted" complaints handling for prisoners from HMP Barlinnie, Low Moss and Greenock. It had adopted a policy of seeking to resolve complaints at local level within three working days under the complaints procedure where a resolution could be mutually agreed with the patient. This had seen 35% of all complaints resolved locally between healthcare staff and patients. Councillor O'Donnell asked a follow up question about how prison complaints handling and performance fed into the Community Justice Authority. Ms Crocket responded by confirming that the prison health service monitored and would report this to prison governors to consider in accordance with their own governance processes.

NOTED

30. ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS – STANDING ORDERS, COMMITTEE REMITS AND MEMBERSHIPS AND OTHER ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No 14/16a] asked the NHS Board to approve, note and agree any revisions to the governance arrangements in place within NHS Greater Glasgow and Clyde.

Mr Hamilton reminded the NHS Board that, in February 2005, it approved the new organisational arrangements to implement the White Paper "Partnership for Care". Subsequently, two significant reviews of the governance arrangements had taken place as the moves to single system working and integration of Clyde were carried out and, as a result, the NHS Board approved in December 2006, a detailed set of new governance arrangements to support the new organisation.

In response to the launch of the Quality Strategy and the need to embed its requirements within corporate reporting and governance structures, the NHS Board had considered an integrated approach to performance reporting and established the Quality and Performance Committee from July 2011 to carry out these functions.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board properly to discharge its responsibilities and statutory functions. The Audit Committee, at its meeting on 5 March 2014, reviewed the paperwork associated with the Annual Review of Corporate Governance and was content with the changes submitted and endorsed the arrangements for the NHS Board's consideration.

A review of Standing Financial Instructions (SFIs) and Scheme of Delegation had been undertaken by the Director of Finance and his team. He intended to carry out a further and fundamental review of these once the arrangements for the Joint Integrated Boards were further developed and better understood.

DECIDED

(i) That the Standing Orders for the Proceedings and Business of the NHS Board and the Decisions Reserved for the NHS Board [Appendix 1] be approved. **Head of Board Administration**

(ii) That the remits of the Standing Committees – Quality and Performance Committee [Appendix 2], Audit Committee [Appendix 3], Pharmacy Practices Committee [Appendix 4] and Area Clinical Forum [Appendix 5] be approved. **Head of Board Administration**

(iii) That the memberships of the Standing and Subcommittees [Appendix 6] be approved. **Head of Board Administration**

(iv) That the membership of the Adults with Incapacity Supervisory Body [Appendix 7] be approved. **Head of Board Administration**

(v) That the list of Authorised Officers to sign Healthcare Agreements and related contracts [Appendix 8] be approved. **Head of Board Administration**

(vi) That the delegation to the Medical Director (or nominated representative during periods of leave) and Director of Public Health (or nominated representative during periods of leave) to approve medical practitioners under Section 22 of the Act to carry out the designated tasks described in Section G of this report with effect from 16 April 2014 be approved. **Medical Director/ Director of Public Health**

31. REVIEW OF FINANCIAL GOVERNANCE

A report of the Director of Finance [Board Paper No 14/16b] asked the NHS Board to approve the proposed Standing Financial Instructions and Scheme of Delegation.

Mr James reported that, following a review, it was identified that there were a number of areas in which the NHS Board's Standing Financial Instructions were out of date. It was also identified that a large number of changes would be needed in order to ensure that the SFIs were fit for purpose when the integration of health and social services was implemented in 2015. Given this, at a Corporate Management Team meeting in November 2013, it was agreed to amend the SFIs in two phases. The first phase would focus only on the changes needed in order to bring the SFIs up to date for 2013/14. That had been done and was reflected in the NHS Board paper. The second phase which would be developed over 2014 for subsequent NHS Board approval, would involve significant further change to accommodate the advent of the new Health and Social Care Partnerships.

Mr James led the NHS Board through the key changes proposed to bring the SFIs up to date and explained that these had been discussed by the Audit Committee at its meeting on 5 March 2014 when they were endorsed and agreed for presentation to the NHS Board for final approval. Since that time, however, there had been a meeting of the NHS Board's Quality and Performance Committee at which changes to its remit were discussed and agreed, some of which related to Capital Expenditure. The changes proposed for the Quality and Performance Committee prompted further discussions about the SFIs and, as a result, some further changes had since been incorporated which Mr James highlighted.

Mr Finnie drew attention to various inconsistencies in the document and Mr James agreed that a further update was necessary. Given this, Mr James suggested he update and amend the document and re-circulate it to all NHS Board Members for completeness. **Director of Finance**

DECIDED

- That, the proposed Standing Financial Instructions and Scheme of Delegation

be approved pending the amendment of some inconsistencies by the Director of Finance. **Director of Finance**

32. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No 14/17] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED

That the nine Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved. **Director of Public Health**

33. AREA CLINICAL FORUM MINUTES: 6 FEBRUARY 2014

The minutes of the Area Clinical Forum meeting held on 6 February 2014 [ACF(M)14/01] were noted.

In response to a question from Dr Benton regarding the Staff Survey results, Ms Renfrew reported that a sub group of the Area Partnership Forum had been set up to scrutinise the detail of this and she agreed to share the details with her. **Director of Corporate Planning & Policy**

NOTED

34. PHARMACY PRACTICES COMMITTEE MINUTES: 16 JANUARY 2014

The minutes of the Pharmacy Practices Committee meeting held on 16 January 2014 [PPC(M)14/01] were noted.

NOTED

35. AUDIT COMMITTEE MINUTES: 5 MARCH 2014

The minutes of the Audit Committee meeting held on 5 March 2014 [A(M)14/01] were noted.

NOTED

The meeting ended at 12.20pm

NHSGG&C(M)14/04
Minutes: 57 - 72

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Corporate Headquarters, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH on Tuesday, 19 August 2014 at 9:30a.m.

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Councillor A Lafferty
Dr C Benton MBE	Mr I Lee
Ms M Brown	Mrs T McAuley
Mr R Calderwood	Councillor M Macmillan
Dr H Cameron	Councillor J McIlwee
Mr G Carson	Ms R Micklem
Ms R Crocket MBE	Councillor M O'Donnell
Mr P Daniels OBE	Dr R Reid
Dr L de Caestecker	Councillor M Rooney
Councillor M Devlin	Rev Dr N Shanks
Professor A Dominiczak	Mr D Sime
Mr R Finnie	Mr K Winter

IN ATTENDANCE

Mr G Archibald	Lead Director, Acute Services Division
Mr R Garscadden	Director of Corporate Affairs
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms A Harkness	Director of Emergency Care and Medical Services
Mr J Hobson	Interim Director of Finance
Mr K Redpath	Director Representative for Partnerships
Mr I Reid	Director of Human Resources
Mr D Walker	Director, Glasgow City CHP (South Sector)

ACTION BY

57. WELCOME AND APOLOGIES

Mr Robertson welcomed Mrs T McAuley to her first NHS Board meeting as a newly appointed Non-Executive Member. He also introduced Dr D Lyons who had also been appointed but who had submitted his apologies for this meeting. The Chair of National Services Scotland, Ms E Ireland, was in attendance to observe the proceedings of the NHS Board meeting and Mr Robertson extended a warm welcome to her.

Apologies for absence were intimated on behalf of Councillor M Cunning, Mr I Fraser and Dr D Lyons.

NOTED

58. DECLARATION(S) OF INTEREST(S)

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

NOTED

59. CHAIR'S REPORT

(i) On 25 June 2014, Mr Robertson attended the official opening of the new Lister Building at Glasgow Royal Infirmary. This was opened by the Cabinet Secretary for Health and Wellbeing and the £15m major refurbishment included three floors for NHSGGC Laboratory Services and two floors for the University of Glasgow and represented one of the most modern in the UK, providing first class, 21st century facilities from both.

(ii) On 26 June 2014, Mr Robertson attended the "Release Potential Campaign – Staff Engagement Event", the aim of which was to talk to disabled staff about their experiences and how things could be improved so that they felt able to tell their managers about their impairment and also so that managers understood the benefits of a workplace that supported disabled people. The event gave an insight into a range of experiences of staff with a disability and a report would be drawn up summarising the key themes raised.

(iii) Mr Robertson continued to visit last year's Chairman's Award winners in their own work areas which he was finding enlightening in terms of how lessons were being learned to improve services within local areas and, furthermore, being rolled out wider across NHSGGC.

(iv) On 24 July 2014, along with other NHS Board Members, Mr Robertson attended the Topping Out Ceremony (performed by the Cabinet Secretary for Health and Wellbeing) of the new Teaching and Learning Centre at the new Southside Hospital development. This Centre was developed jointly by NHSGGC and the University of Glasgow and was an investment of £27m to provide a training environment for the clinical years of the undergraduate medical degree, post graduate training facilities for medical staff and a large variety of NHS professionals. It would ensure that training of the next generation of doctors, scientists, clinical academics and support staff could be undertaken. The new Centre would replace facilities at the Western Infirmary, Victoria Infirmary, Southern General and the Royal Hospital for Sick Children which would all close following the transfer of clinical services to the new Southside Hospital site.

(v) On 31 July 2014, Mr Robertson attended the National Young Carers Festival at West Linton. This was an excellent event attended by around 700 young carers and provided an opportunity to share their good and bad experiences, highlighting where improvements could be made.

(vi) On 7 August 2014, Mr Robertson hosted a Thank You Afternoon Tea for volunteers and staff of the Royal Voluntary Service (RVS) as well as NHSGGC staff who had benefited from their "Gifting Fund" which included the gifts of a replacement private ambulance and a special garden designed at the Langlands Unit.

(vii) Councillor Rooney commended the NHS Board's preparation and contingency plans in light of the success of the Commonwealth Games. He took the opportunity to celebrate the achievement and praised staff for their excellent

planning and service delivery throughout the Queen's Baton Relay and the Commonwealth Games themselves. Dr Armstrong agreed and alluded to official feedback from the Organisation Committee of the Commonwealth Games Glasgow 2014, who had confirmed excellent support and input from NHS staff. Mr Robertson acknowledged this and suggested the full report of the Organisation Committee be considered at a future NHS Board meeting.

Director of Public Health

NOTED

60. CHIEF EXECUTIVE'S UPDATE

(i) On 31 July 2014, Mr Calderwood addressed the Greater Glasgow and Clyde branch of Unite the Union. He outlined NHSGGC service provision from 2015 onwards and looked at services going forward in relation to Acute Services Implementation, Finance, Health and Social Care Integration, Clinical Services Review and Management Restructuring.

(ii) On 5 August 2014, Mr Calderwood met with Dr F G Dunn, President, Royal College of Physicians and Surgeons of Glasgow, to discuss the difficulties of delivering the PACES examination within the NHSGGC area. The challenges had been in identifying sufficient examiners and the requisite space within the NHSGGC area. Mr Calderwood agreed to work with Dr Dunn to try to accommodate dedicated clinical skills areas at the Southside Hospital and Glasgow Royal Infirmary.

(iii) On 14 August 2014, Mr Calderwood delivered a presentation to the Holyrood Summer School held at Stirling University on "Delivering World-Class Healthcare and the Challenges of the Next Five Years". The interaction with the participants had been insightful.

NOTED

61. MINUTES

On the motion of Dr R Reid, seconded by Mr D Sime, the Minutes of the NHS Board meeting held on Tuesday, 24 June [NHSGGC(M)14/03] were approved as an accurate record and signed by the Chair.

NOTED

62. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of matters arising was noted.

(ii) In response to a question from Councillor Rooney concerning Minute No 44 (Keep Well Programme), Dr de Caestecker reported that an EQIA had not been carried out in relation to Keep Well nationally but that this had been looked at locally.

(iii) In response to a question from Councillor Rooney concerning Minute No 48 (Capital Plan: 2014/15 to 2016/17), Mr Calderwood confirmed that £1.1m remained unallocated at that time. All unallocated funds were reviewed every 2/3 months to review progress and consider proposals for their reallocation.

NOTED

63. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 14/44] asked the NHS Board to note the high level overview report on the Maternity and Children Quality Improvement Collaborative (MCQIC) which encompassed the clinical improvement activity of the Scottish Patient Safety Programme's (SPSP) maternity, neonatal and paediatric strands. Its overall aim was to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families in Scotland. It was launched in March 2013 and would run until December 2015.

Ms Crocket led the NHS Board firstly through an update on the maternity workstream and secondly the paediatric and neonatal workstream. She explained that there were three major obstetric care sites within NHSGGC. All three had been well engaged and were demonstrating good levels of progress in implementing the National Programme aims of the maternity workstream which aimed to support clinical teams to improve the quality and safety of maternity healthcare. She provided a snapshot of the measurement activity from each of the sites and cited examples and challenges that demonstrated a broad scope of activity generated in the first year including:-

- Person-centred care;
- Leadership and culture;
- Teamwork, communication and collaboration;
- Safe, effective and reliable care;
- Key outcome measures.

In going forward, Ms Crocket reported that each team had a local plan for further development.

In terms of the paediatric and neonatal workstream, there were currently 20 teams supported across paediatric and neonatal services. She highlighted the areas of particular success and reported that neonatal teams had agreed the use of the national toolkit in order to submit their data to the local data team for monthly collation and reporting.

Mr Sime asked if there was a mechanism in place to standardise the SPSP for the Maternity and Children Quality Improvement Collaborative. Ms Crocket confirmed that NHSGGC was working with other NHS Boards who had a paediatric hospital to look at how this could be coordinated nationally.

Ms Micklem found the report helpful but sought further information about the two workstreams in terms of baseline information and how NHSGGC was performing when compared to other NHS Scotland Boards (and the wider UK). Ms Crocket agreed to provide Ms Micklem with this information. **Nurse Director**

NOTED

64. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/45] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs). For the last available reporting quarter (January to March 2014), NHSGGC reported 26.3 cases per 100,000 AOBDs. NHS Scotland reported 28.4 cases per 100,000 AOBDs. These were the lowest SAB rates achieved to date. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, January to March 2014, NHSGGC reported 24.1 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 28.7 per 100,000 AOBDs. This was the lowest rate to date.

For the last available quarter (January to March 2014), the surgical site infection (SSI) rates for all procedures were below the national average with the exception of the repair of neck femur procedure category which was slightly above although remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,158 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong summarised the requirements and actions from an unannounced Healthcare Environment Inspectorate (HEI) inspection at the Princess Royal Maternity Hospital on 30 April 2014. She also alluded to norovirus activity which saw one ward closed (in one hospital) throughout May and June 2014.

Councillor Rooney commended the good progress made in meeting the targets in Healthcare Associated Infections since 2007/08. He also asked about the healthcare associated infection report cards that provided information for each acute hospital and key community hospital within NHSGGC. Dr Armstrong explained that it was important to understand the source of infections either from hospitals and/or community sources so that there was a geographical focus, if and when, any infections increased. It also helped in looking at prescribing patterns and the use of antibiotics within geographical communities.

Dr Benton asked about continuous improvement measures in place. Dr Armstrong summarised ongoing learning and training undertaken in respect of central vascular catheters (CVC) and peripheral vascular catheters (PVC) and how/when they were inserted/removed. This was achieved by ensuring staff were aware and adhered to best practice and completed the accompanying care bundle documentation to ensure the risk

of infection to patients was minimised.

In response to a question from Councillor Rooney concerning the public inquiry into the Vale of Leven Hospital, Mr Calderwood reported that, in accordance with the Vale of Leven Hospital Inquiry website, its Chairman (the Right Honourable Lord MacLean) had now considered each of the responses to the warning letters issued. As the responses received were both lengthy and detailed, this process had taken some time and that had now been concluded with any necessary amendments being made to the report. Once the amendments had been made, the whole report would then be reviewed in preparation for submission to the publishers.

NOTED

65. UNSCHEDULED CARE

A report of the Director of Emergency Care and Medical Services, Acute Services Division [Board Paper No 14/46] asked the NHS Board to note developments with the Local Unscheduled Care Plan, ongoing service redesign work between NHS services and its partners, and approve the allocation of £1.1m additional investment required in 2014/15.

Ms Harkness reported that, in 2013, the Scottish Government announced a three year National Unscheduled Care Programme designed to ensure that patients were admitted or discharged from emergency departments as soon as possible with a view to ensuring that 95% of patients were treated in accordance with the standard by September 2014 and 98% by April 2015. NHSGGC prepared a Local Unscheduled Care Action Plan and this was approved by a National Evaluation Panel on 31 July 2014.

Ms Harkness recorded that NHS Board performance had been at 90% for recent months with most patients waiting in an Emergency Department for an inpatient bed to be made available. A review of activity had been undertaken and illustrated that, while the number of patients attending Emergency Departments and Minor Injuries Units remained static in 2013/14, the number of people admitted following an Emergency Department attendance had risen by 2.4% compared with the previous year. By the end of June 2014, attendances were 2.6% higher than the first quarter last year.

Ms Harkness led the NHS Board through some service improvement initiatives undertaken including the following:-

- Working with partner agencies was key to ensuring that people received the right care, in the right place at the right time.

- Work across NHS services (acute and community services) to ensure that people could be cared for at home or in a homely setting for a long as possible and were discharged as soon as they were ready for this to take place.

- Work within Acute Services looking at local processes to ensure that discharge decisions were implemented as soon as possible.

Ms Harkness explained that, whilst service redesign and joint work continued to make progress, the results could take some time to deliver sustained improvement. There was, therefore, a need to take a number of immediate actions in order to ensure that patients could be admitted from NHSGGC's Emergency Departments.

Inpatient beds were a rapid solution to the issue and could be closed equally rapidly when the impact of other initiatives was felt – it was proposed to open additional beds on three hospital sites.

Furthermore, a review by a senior decision maker was required to ensure that patients had been promptly assessed, treatment initiated, and a care plan agreed. It was proposed to appoint a medical nurse practitioner to work at Inverclyde Royal Hospital – all other sites currently had this resource, however, it was also proposed to increase emergency nurse practitioner hours in the Emergency Department at the Royal Alexandra Hospital and to appoint four additional consultant physicians. A surgical assessment area would also be established at the Royal Alexandra Hospital to allow patients to move more quickly from the Emergency Department to specialist care.

A number of other initiatives would also be taken forward by local services and this would require additional investment of £1.1m by the NHS Board (in addition to the Local Unscheduled Care Action Plan allocation). The impact of these actions would be evaluated and, should they deliver the planned levels of improvement, they would be recommended for consideration for ongoing investment in 2015/16.

Mr Walker summarised the core elements of a report prepared by Glasgow City Social Work Services, Glasgow CHP and the Acute Services Division setting out the wider context within which a shifting of care for older people could be achieved over the course of the next four years and, at the same time, outlined the actions that were proposed to improve hospital discharge arrangements in 2014/15. He led the NHS Board through the key issues including the plan to reconfigure the balance of community-based health and social care for older people and the core elements of the proposed change programme including the potential impact on hospital delays this financial year. He outlined how the development would be funded on a recurring basis from 2015/16 and identified the need for transitional resource this year to address the reduced levels of care home funding and ease the anticipated pressures whilst the planned programme of change was implemented.

Mr Walker summarised the projected shift in the balance of care in financial terms and projected numbers of people supported over what would be a very challenging four years. He confirmed the projected shift in available resources away from long-term care to intermediate care, reablement, day care, telecare and community-based healthcare including rehabilitation. He explained that the continued risk remained the mismatch between available supply and demand for care home placements, particularly where the hospital system experienced unexplained surges in demand.

Mr Walker went on to describe the in-year actions required to improve discharge performance and the continuing gap between the available care home budget and demand for placements. The impact of this gap was that if no action was taken by the end of this financial year there could be approximately 160 further patients delayed in hospital awaiting funding. He set out the capacity gains and financial costs associated with meeting this pressure, at the centre of which was a redesign/improvement plan to significantly increase the levels of intermediate care capacity in the city from the present 37 to 115 places. The hypothesis underpinning the redesign was that, by facilitating discharge from the acute care system at (or close to) the "fit for discharge" date, followed by comprehensive assessment, with access to intensive rehabilitation and other appropriate care that a proportion of people could be returned to their own homes rather than be placed permanently in a care home.

In response to a question from the Chairman, Mr Walker confirmed that the Council was currently considering the provision of additional in-year financial support.

In response to a question from Rev Dr Shanks, Mr Walker indicated that successful implementation of the improvement plan should deliver significant improvements in terms of a sharp reduction in the number of patients awaiting discharge coupled with better outcomes for patients particularly if more could be returned to their own homes. In terms of whether accommodation was immediately available for intermediate care,

Mr Walker indicated that this would likely come from a combination of the private care home sector and the Council's new residential care programme which would see five new care homes opening in Glasgow in the space of the next 12 months. In terms of the assessment of patients, the aim under the plan would be to discharge suitable patients from hospital as soon as possible so that assessments were not undertaken in a hospital environment. Mr Walker conceded that work still had to be undertaken to iron out issues of consent and who had to be involved in that process.

In relation to the financial framework, Mr Calderwood confirmed that the full year cost of the improvement plan, totalling £3.764m, would be a first call on the Integrated Care Fund received by Glasgow in 2015/16 and, thereafter, funded from within the residential/nursing budget to be managed by the new HSCP. However, in the current year, there remained a significant financial shortfall to meet the gap between the available care home budget and demand for placements and, at the same time, the need to initiate the improvement plan.

Councillor Rooney also alluded to the £1.2m deficit being reported, as at 30 June 2014, by the NHS Board and wondered how, in light of this, an additional £1.1m could be found for this purpose. Mr Hobson recognised this additional pressure on the budget but it was considered that it would be containable within exciting resources. In addition, there would need to be an assessment undertaken to establish if the proposed model was working and whether having patients return to their home (either unsupported or in a supported care package) did reduce the spend in acute beds.

In response to a question about the Change Fund, Mr Calderwood agreed that there was concern regarding this future funding source and clarity was awaited. All NHS Boards and Local Authorities faced major choices in the future if there were changes made to the Change Fund.

Mr Carson referred to a lack of accessible housing for people with disabilities and encouraged NHSGGC to work with partners to address this. Mr Walker agreed and reported that Glasgow City had over 60 housing associations and that the Partnership would continue to work with them in the future as part of the wider Reshaping Care arrangements.

In response to Councillor O'Donnell's point regarding future available funds, Mr Calderwood commented that all public partners were considering and assessing spending. In the NHS in particular, all parts of the system were seeing a rise in demand so the redesign of services had to be undertaken around static resources and this was a huge challenge going forward.

In response to further questions, Mr Calderwood emphasised that, fundamentally, NHSGGC was working to achieve the discharge of suitable assessed patients after an acute intervention and this proposal was a non-recurring package for 2014/15. A number of initiatives may prove to be successful so it may be that these were considered for mainstreamed funding from 2015/16 onwards.

Dr Reid supported the proposals as did Mr Finnie, following Mr Calderwood's clarification particularly in looking at the expenditure elements. There was appreciation of the difficulty in looking objectively at planning patient care going forward against the challenge of meeting financial obligations.

Councillor Macmillan also welcomed the paper and summarised work being carried out in Renfrewshire CHP (alongside the Council's Social Work department). He also agreed that there was a huge pressure on NHS Boards and Local Authorities in terms of amendments to the Change Fund but appreciated that this was likely to be discussed in the future.

Ms Brown considered that the paper should have made reference to community health services, nurses, GPs and palliative care in the community to provide a whole system approach for "hospital to home". She appreciated that the documents being considered was a summary, but would like to see the full strategy outlining the proposals for the four years going forward. Ms Harkness described the huge amount of work going on and indicated that this aspect had been referred to in her paper. Mr Walker agreed to circulate the strategy document to Members. Dr Cameron agreed that this would be useful, particularly in seeking reassurance around future workforce planning.

Director, Glasgow City CHP (South Sector)

DECIDED

- That, the Local Unscheduled Care Plan had been approved by the Government with an associated allocation of £1,766,457m be noted.
- That, the Government had funded an additional £1,100,000m to facilitate the discharge of Glasgow City Council residents from hospital be noted.
- That, the ongoing Service Redesign work in NHS services and with partners be noted.
- That, the allocation of £1,100,000m additional investment required in 2014/15 be approved.

Director, Emergency Care & Medical Services

- That, the elements of this would require to be considered as part of the Board's financial plan for 2015/16 and beyond be noted.

66. NEW SOUTHSIDE HOSPITALS - NAMING

A report of the Chief Executive [Board Paper No 14/47] asked the NHS Board to agree that the new Adult Hospital be named the South Glasgow University Hospital and that the new Children's Hospital be named the Royal Hospital for Sick Children.

Mr Calderwood explained that the stage had been reached where the next step was to begin to order the hospital signage for the neighbouring streets around the hospitals and internally within the hospital campus. It was important to recognise that the new Adult Hospital brought together three hospitals into one site (Southern General Hospital, Western Infirmary and Victoria Infirmary). In addition, the new hospital campus would have a major university presence particularly in relation to the Teaching and Learning Centre, Centre for Stratified Medicine and the Clinical Research Facilities on site. To give full and proper recognition to the amalgamation of the three hospitals on the new Southside campus, its location and the significant partnership work with the University of Glasgow, it was proposed to name the new Adult Hospital the South Glasgow University Hospital.

As with the Adult Hospital, signage also needed to be ordered for the new Children's Hospital. Mr Calderwood explained that it was not considered necessary to change the name of the Children's Hospital from its current name as the Royal Hospital for Sick Children. It had a proud and long history of providing care and treatment to children from all over Scotland for many decades and it was not bringing different hospitals together onto one site.

It was, therefore, recommended that the name of the new Children's Hospital on the South Glasgow campus be the Royal Sick Hospital for Sick Children.

Mr Calderwood acknowledged that requests had been made to give recognition to

some historical and significant names within the hospitals involved in the migration. This would be fully discussed with the interested parties and due recognition would be given to the requests received, where considered appropriate, recognising that this was a new hospital and naming of the wards had been planned in order to assist the movement and flow of patients around these two new complexes.

Professor Dominiczak welcomed both names and considered that it represented the excellent partnership work between NHSGGC and the University of Glasgow.

Some members enquired why the word "South" was being retained particularly given that the new hospital had a much wider catchment than South Glasgow. The consensus was, however, support for the proposed name.

DECIDED

- That, the new Adult Hospital be named the South Glasgow University Hospital. **Chief Executive**

- That, the new Children's Hospital be named the Royal Hospital for Sick Children. **Chief Executive**

67. WAITING TIMES AND ACCESS TARGETS

A report of the Interim Lead Director, Acute Services Division [Board Paper No 14/48] asked the NHS Board to note progress against the national targets as at the end of June 2014.

Mr Archibald led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times - 18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Mr Archibald reported that two inpatients had breached the national treatment time guarantee of 12 weeks from decision to treat and explained that, in both instances, the patients were not added to the waiting list at the correct time due to administrative errors. As such, processes had since been reviewed to ensure that this did not occur in future.

In respect of outpatients, 77 ophthalmology and 6 neurology patients waited over 12 weeks and Mr Archibald reported significant demand and capacity pressures in both of these specialties which was a national issue and not limited to NHSGGC. He led the NHS Board through further background information and details of the specific planned actions taken by both services.

In respect of Accident & Emergency waiting times, 42 patients waited over 12 hours to the conclusion of treatment and NHSGGC's performance for the quarter overall was 90.1% (the national target was 98%).

Councillor O'Donnell referred to the term "breachers" when a patient had not been seen within a specific target period. Disappointingly, this term was now being used in frontline services and by staff which gave the perception of there being a problem with the patient. Mr Archibald agreed to consider a more suitable alternative phrase when reporting to the NHS Board. **Interim Lead Director (Acute Services)**

Councillor Rooney asked about patient "unavailability" and Mr Archibald explained that many NHS Boards were strictly interpreting the access provision and returning patients to the care of their GP if they had declined two reasonable offers. This practice had not been adopted in NHSGGC and the Acute Services Division continued to seek to provide patients with access to their nearest hospital, where at all possible. This had the effect of increasing patient unavailability. To draw any comparison, therefore, with other Boards was difficult as they applied the rules differently and NHSGGC chose to maximise access to its patients.

Mrs McAuley welcomed the overall focus on finding solutions that this report demonstrated. She referred, in particular, to the specific challenges at the Victoria Infirmary in meeting the stroke target. Mr Archibald explained that plans were in place to change the stroke admission pathway at the Victoria Infirmary so that all patients from that catchment area were being admitted consistently to the Southern General Hospital, replacing the current inconsistent pathway. This change would be implemented on 1 September 2014 and would be reflected in reporting information from that date onwards.

Mr Daniels asked about the seven patients awaiting spinal surgery whose care and treatment had not been provided within the treatment time guarantee. Mr Archibald reported that arrangements had been made for these patients to have their operations delivered by Ross Hall Hospital within the 12 week waiting time guarantee. The hospital had then been unable to provide the operations as required. This matter was being taken forward with Ross Hall (this arrangement was set up by the Scottish Government) and alternative arrangements had been made for the patients to have their operations.

NOTED

68. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2014

Mr Hobson reported that, as at 30 June 2014, the NHS Board was reporting expenditure levels of £1.2m over budget. This was close to the NHS Board's planned trajectory to achieve break-even by 31 March 2015. At this stage of the year, the NHS Board was also close to its year-to-date cost savings target against plan. In terms of capital expenditure, the first quarter amounted to £22.6m and it was anticipated that a balanced year-end position would be achieved.

In response to a question from Councillor Rooney, Mr Hobson confirmed that the £1.2m deficit did not take account of the decision made earlier on Unscheduled Care investment.

NOTED

69. FREEDOM OF INFORMATION MONITORING REPORT FOR THE PERIOD 1 APRIL 2013 TO 31 MARCH 2014

A report of the Head of Board Administration [Board Paper No 14/50] asked the NHS Board to note the Annual Monitoring Report on the operation of the Freedom of Information (FOI) (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations (EIR) 2004 within NHSGGC for the period 1 April 2013 to 31 March 2014.

Mr Hamilton reported that the overall number of FOI / EIR requests received by NHSGGC during 2013/14 showed an increase of approximately 29% on 2012/13. The

distribution of FOIs varied from month to month with an average of 65 requests per month.

Mr Hamilton led the NHS Board through the report which detailed, amongst other issues, the source of requests, the type of information requested, performance monitoring and requests for review. He also indicated that Mrs Flynn, FOI Manager, had been successful in gaining the Practitioner Certificate in FOI (Scotland) with distinction.

In response to a question from Mrs McAuley, Mr Hamilton explained that all NHSGGC staff had access to an e-learning training module for both the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. Their aim was to increase the knowledge and understanding within the organisation so that performance against legislative timescales continued to improve and the culture of FOI within the organisation developed. He agreed that NHSGGC also learned lessons from the outcomes of requests for review and decisions issued by the Scottish Information Commissioner. Use was made of the Act's provisions to provide advice and assistance to requesters where necessary, however, maybe more needed to be done to support those groups who did not make many requests.

Councillor Rooney asked if NHSGGC charged for providing a response in accordance with the Act. Mr Hamilton reported that NHSGGC did not charge for meeting requests.

NOTED

70. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 1 JULY 2014

The Minutes of the Quality and Performance Committee meetings held on 1 July 2014 [QPC(M)14/03] were noted.

NOTED

71. AREA CLINICAL FORUM MINUTES: 5 JUNE 2014

The Minutes of the Area Clinical Forum meeting held on 5 June 2014 [ACF(M)14/03] were noted.

NOTED

72. AUDIT COMMITTEE MINUTES: 17 JUNE 2014

The Minutes of the Audit Committee meeting held on 17 June 2014 [A(M)14/03] were noted.

NOTED

The meeting ended at 11.30am

NHSGG&C(M)14/06
Minutes: 91 - 110

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Corporate Headquarters, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH on Tuesday, 16 December 2014 at 9:30a.m.

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong	Mr I Lee
Dr C Benton MBE	Dr D Lyons
Ms M Brown	Councillor M Macmillan
Mr R Calderwood	Councillor J McIlwee
Dr H Cameron	Ms R Micklem
Ms R Crocket MBE	Councillor M O'Donnell
Dr L de Caestecker	Councillor M Rooney
Mr R Finnie	Mr D Sime
Mr I Fraser	Mr K Winter

IN ATTENDANCE

Mr A Curran	Head of Capital Planning & Procurement
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms A Harkness	Director, Emergency Care & Medical Services
Mr J Hobson	Interim Director of Finance
Ms K Murray	Interim Chief Officer, East Dunbartonshire CHP
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy

ACTION BY

91. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Brown CBE, Councillor M Cunning, Mr P Daniels OBE, Councillor M Devlin, Professor A Dominiczak, Councillor A Lafferty, Mrs T McAuley, Dr R Reid, Rev Dr N Shanks.

NOTED

92. DECLARATION(S) OF INTEREST(S)

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

NOTED

93. CHAIR'S REPORT

(i) Mr Robertson notified the NHS Board that it was likely there would be the need to hold an additional NHS Board meeting on 20 January 2015 to finalise and approve the re-structure of the new Health and Social Care Partnership Joint Integrated Boards. He anticipated a short NHS Board meeting to do this followed by the pre-arranged Quality and Performance Committee meeting.

(ii) On 23 October 2014, Mr Robertson attended the official opening of the Clinical Research Facility at the Dental Hospital and School.

(iii) On 24 October 2014, Mr Robertson met with partners involved in the greening of the Gartnavel Campus which had been officially opened by the then Cabinet Secretary for Health and Wellbeing, Mr A Neil MSP.

(iv) On 14 November 2014, Mr Robertson attended the Inverclyde League of Friends AGM in Greenock.

(v) On 17 November 2014, Mr Robertson attended the Chairman's Celebratory Awards Dinner with around 300 members of staff in attendance. Mr Sime commended this event which had been well received by nominees, winners and their peers. Feedback from the ceremony had been excellent.

(vi) On 24 November 2014, the Right Honourable Lord MacLean issued the final report of the Vale of Leven Hospital Inquiry – this would be discussed in further detail at Item Number 10 of the Board Agenda.

(vii) On 28 November 2014, Mr Robertson and the Chief Executive toured the new South Glasgow University Hospitals with Ms H Puttick and Mr M Llewellyn, both from the Herald newspaper.

(viii) On 3 December 2014, Mr Robertson with Mr Hamilton attended the NHS Retirement Fellowship lunch.

(ix) On 8 and 9 December 2014, Mr Robertson along with other NHS Board Members, attended the NHS Board's Offsite Strategy Event.

(x) On 15 December 2014, Mr Robertson hosted a visit from the Cabinet Secretary for Health and Wellbeing, Ms S Robison MSP. This provided an opportunity for her to visit Ward 65 at Glasgow Royal Infirmary and to discuss the recent Healthcare Environment Inspectorate (HEI) report with staff.

(xi) On the evening of 15 December 2014, Mr Robertson attended the University of Glasgow Academic Awards ceremony which recognised the contribution of NHSGGC's medical staff to medical education.

NOTED

94. CHIEF EXECUTIVE'S UPDATE

(i) On 25 October 2014, Mr Calderwood attended the 50th Anniversary Dinner of the Walton Foundation to celebrate their support to medical education and research.

(ii) On 30 October 2014, Mr Calderwood attended the hub West of Scotland Annual Shareholders' Dinner.

(iii) On 3 November 2014, Mr Calderwood attended the Golden Jubilee National Hospital for a lecture on the five steps to achieve high quality healthcare in uncertain times given by Derek Feeley, former Director General of NHS Scotland.

(iv) On 5 November 2014, Mr Calderwood met with Miss S Cardle and Ms K Sinclair to discuss further the fundraising campaign for the Yorkhill Children's Charity and how this would continue when the new hospital was complete on the South Glasgow University Hospitals campus.

(v) On 14 November 2014, Mr Calderwood attended the NHS Staff Council in London.

(vi) On 21 November 2014, Mr Calderwood, attended the IHM Northern Ireland conference and delivered a presentation on "Delivering Safe, Efficient Quality Care – a Scottish Perspective".

(vii) On 27 and 28 November 2014, Sir Peter Housden hosted the annual Scottish Leadership Forum at the Beardmore Hotel.

(viii) On 4 December 2014, Mr Calderwood met with Councillor J Coleman, Glasgow City Council, to discuss further the provision of bus services by SPT to the new South Glasgow University Hospitals.

(ix) On 10 December 2014, Mr Calderwood met with Councillor A Watson and Mr B Devlin from Glasgow City Council to discuss further car parking at the new South Glasgow University Hospitals. They had agreed to arrange a tri-partite meeting in the New Year with the three partners (the NHS Board, Glasgow City Council and SPT) going forward.

(x) On 11 December 2014, Mr Calderwood attended the retiral of Mr G Black (Chief Executive, Glasgow City Council) held at the City Chambers.

Councillor Rooney asked for some further information regarding the work being undertaken to address the transport issues to the new South Glasgow University Hospitals. Mr Calderwood highlighted that discussions would focus on a number of aspects to form a programme of work going forward, especially in the North and South corridors of Glasgow. He described that the priority would be to look at connectivity (rail, underground, bus and fastlink) and work would be set in motion to look at routes and timetables alongside interchange opportunities for these modes of transport.

Councillor Rooney also took the opportunity to commend the senior NHS Board team for their conduct on the release of the Vale of Leven Inquiry report. It was clear that the NHS Board immediately apologised and took responsibility for what had occurred in the hospital in 2007/8 and this had been received very positively and gratefully by the affected families.

NOTED

95. MINUTES

On the motion of Councillor J McIlwee, seconded by Councillor M Macmillan, the Minutes of the NHS Board meeting held on Tuesday, 21 October 2014

[NHSGGC(M)14/05] were approved as an accurate record and signed by the Chair.

NOTED

96. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was noted.

NOTED

97. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director [Board Paper No 14/61] asked the NHS Board to note an update on the Scottish Patient Safety Programme (SPSP) for medicines reconciliation and venous thromboembolism (VTE).

Dr Armstrong led the NHS Board through a summary of progress to date in both areas as follows:-

- Medicines Reconciliation Workstream – Dr Armstrong explained that, although there was complementary improvement work underway within Primary Care and Mental Health programmes, her update focused specifically on Medicines Reconciliation in Acute Directorates. Medicines Reconciliation was the process of ensuring that patients were prescribed the correct medicines, in the correct doses appropriate to their current clinical presentation and that avoidable harm from medicines was reduced. Accurate, timely medicines reconciliation on admission to (and discharge from) hospital was an integral part of clinical care. Dr Armstrong outlined the goals and measures used for both Medicines Reconciliation on admission and discharge from hospital.

  With regard to admission to hospital, the Medicines Reconciliation process started in clinical areas where patients were directly admitted to hospital, so that had been the focus of the programme to date. Target wards had been identified across all Acute Directorates. As part of the spread plan, the Directorates had identified sets of priority wards, usually with larger numbers of patient admissions. Those wards had been supported by the programme manager and clinical pharmacy to use the model for improvement to test and modify their Medicines Reconciliation process.

  With regard to Medicines Reconciliation at discharge from hospital, the ability to perform this effectively relied on it being done well on admission. The programme was, therefore, focused on improving Medicines Reconciliation on admission before formalising to target discharge. In preparation for this work, however, the Department of Medicine for the Elderly wards at Glasgow Royal Infirmary had been doing some testing and measuring in this area.

  Dr Armstrong illustrated the results so far, explaining that, at the last review of progress in the Acute Services Division, specific improvements were noted in medical, cardiology, neurosurgery and renal services as well as a few surgical wards such as orthopaedic trauma at Glasgow Royal Infirmary. She described some of the challenges and further areas for development which included a change in the way NHSGGC assessed completion of the Medicines Reconciliation form.

- Venous Thromboembolism (VTE) Workstream – Historically, the risk of VTE and the benefit of prevention had been well recognised and a range of preventative measures had been instituted in healthcare. There was variation in the conduct of formalised documented VTE risk assessment, which contributed to inappropriately prescribed thromboprophylaxis either through omission in high risk patients or unnecessary administration in those at low risk. It was difficult to quantify the risk and benefit but Dr Armstrong alluded to some estimations made in NHSGGC and described the risks of not assessing for thromboprophylaxis in hospitalised patients. This area of work was looking at the assessment of patients and concurrent administration of interventions to prevent VTE in all patients being admitted for Acute inpatient care. The current aim was that there would be a sustained improvement in delivery of venous thromboembolism risk assessment in 50% of applicable wards by December 2015.

  Dr Armstrong led the NHS Board through the measures being undertaken and provided a summary of progress as well as the proposal that the roll-out plan would be taken forward in three phases. As with other NHS Boards, NHSGGC was challenged by the lack of a national outcome measure for VTE and, as such, NHSGGC was trying to resolve this locally and a new process had been implemented whereby radiologists and sonographers flagged all new pulmonary emboli and deep vein thrombosis on the radiology system with a V flag. Some of the key challenges were highlighted and Dr Armstrong confirmed that clinical teams continued to report that their capacity to engage with the VTE prevention collaborative was limited by the need to also support other programmes of improvement work.

Mr Sime asked how the work on Medicines Reconciliation fitted with the NHS Board's Use of Antibiotics policy. Dr Armstrong confirmed that high-risk antibiotics had strict guidelines and their use was monitored. This had led to a dramatic reduction in C-Diff locally.

Ms Micklem found the report helpful and its honesty, in terms of the complexity of the challenges, was useful. Given that there were no national targets around this work, she thought it would be useful if some aims and objectives could be put in place so that, when monitoring both workstreams, success (or otherwise) was easily identified. Dr Armstrong welcomed this idea and would give it some thought but reiterated that there were no national targets in place as the SPSP ethos was in identifying better ways for teams to work together. **Medical Director**

Mrs Brown agreed with Ms Micklem's point and referred to the numerous strands within the SPSP – this meant it was difficult to keep up with how all were evolving and being rolled out. It would be important to try and be clear about how NHSGGC was ultimately going to reach all the SPSP goals in the long term and she suggested an NHS Board Seminar session looking at overall progress with all the workstreams and how they were pulling together. This suggestion was welcomed. **Medical Director**

In response to a question from Dr Benton, Dr Armstrong cited some examples of junior doctors maintaining good practice in Medicines Reconciliation as they moved between specialties. There was recognition, however, that with the rotation of junior staff through many clinical areas, the supervision by seniors was seen as an important reinforcement. Clinical supervision of junior doctors' compliance with the Medicines Reconciliation process was more challenging in some areas, notably surgical wards, where there was a different model of consultant-led ward rounds than in medical settings.

NOTED

98. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 14/62] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs). For the last available reporting quarter (April to June 2014), NHSGGC reported 29 cases per 100,000 AOBDs. NHS Scotland reported 30.7 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, April to June 2014, NHSGGC reported 26.4 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 33.4 per 100,000 AOBDs.

For the last available quarter (April to June 2014), the surgical site infection (SSI) rates for caesarean section and knee anthroplasty procedure categories remained below the national average. SSI rates for hip anthroplasty and repair of neck of femur procedures, however, were both above the national average although remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,185 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong also reported on local SAB surveillance status information available for quarter 3 (July to September 2014) which indicated that NHSGGC had had a total of 87 patient cases – only four of which were MRSA. This was the lowest ever reporting quarter for NHSGGC with the previous lowest being 96 cases in quarter 3 of 2012. Local estimation of occupied bed day data suggested a rate of 24 cases per 100,000 occupied bed days. Local C-Diff surveillance figures for July to September (quarter 3) 2014 indicated that NHSGGC had had a total of 112 patient cases. Although this was an increase from previous months, only a third of these cases were hospital-acquired and 25 positive samples were obtained from GP practices alone.

Ms Crocket led the NHS Board through the Healthcare Environment Inspectorate (HEI) Glasgow Royal Infirmary report and outlined the findings from their first day of the inspection in the emergency department. She described the action plan put in place following the visit, including an audit of all the emergency departments in NHSGGC as well as the provision of additional training for staff at GRI. All staff working in all emergency departments had since signed a statement indicating that they were aware of their responsibilities and the action plan would be shared with all emergency

departments to ensure that the learning from this inspection could be shared across the piece. As well as the concerns raised about cleanliness of patient equipment, infection control precautions and the care of PVC devices, the inspectors identified a number of staff in breach of the NHSGGC Uniform and Dress Code Policy. This had been addressed.

Ms Crocket referred to Mr Robertson's earlier comment that the Cabinet Secretary for Health and Wellbeing, Ms S Robison MSP, had visited the GRI on 15 December 2014 to discuss this report with staff. She also confirmed that she had met with all lead nurses to reflect on the outcomes of the HEI report and a similar session would be arranged for January 2015 with all senior charge nurses. She reported that staff were disappointed themselves with the findings from the inspection and were anxious to make all necessary improvements.

In response to a question from Councillor Rooney regarding the HEI announced and unannounced inspections, Ms Crocket confirmed that all NHSGGC staff had a responsibility to the NHS Board (as their employer) and to their regulatory bodies. She specified the mandatory requirements in respect of staff training which were intrinsic to their roles. She added that the NHS Board had fully accepted the report and had already undertaken a number of actions for improvement which included:-

- The infection control precautions audit tool would be embedded in the new infection prevention and control audit tool.

- The IPC education strategy had been updated to include infection control precautions as a mandatory element of staff development not only at induction but also as a three-yearly update.

Ms Micklem referred to the 342 reported cases of C-Diff from 1 January to 31 October 2014 in NHSGGC and the fact that local analysis of recurring infections indicated a recurrence of C-Diff in 15% of patient cases. Dr Armstrong reported that, of these 342 patients, in only one case, the patient "caught" it from another patient. Furthermore, a re-infection *was* counted as a new case. In response to a further question, Ms Crocket confirmed that, locally, inspections were carried out in wards and the last GRI emergency department inspection was undertaken in September 2015. She agreed that, when feedback from wards was 95-96% compliance (and, therefore, scored green) it was important to look at the 4-5% reasons for not meeting 100% compliance. Ms Crocket agreed to consider how best this could be reported in future to the NHS Board in a meaningful way. **Nurse Director**

Ms Brown wondered whether NHSGGC needed to review its sanctions for those not meeting compliance in respect of the Uniform Policy. Ms Crocket agreed and reported that a Core Brief had gone out to remind staff of the Uniform Policy and that, from now on, the nurse in charge of each shift would carry out a staff inspection. This would be monitored on an ongoing basis.

NOTED

99. UPDATE ON BIENNIAL DIRECTOR OF PUBLIC HEALTH REPORT ON POPULATION HEALTH IN NHSGGC 2013-2015

A report of the Director of Public Health [Board Paper No 14/63] asked the NHS Board to note progress on the priorities for action identified in the Director of Public Health's report "Building Momentum for Change", published in 2013.

Dr de Caestecker reminded the NHS Board that "Building Momentum for Change" covered the period 2013 to 2015. It highlighted the pivotal importance of poverty and

disadvantage in shaping health at three key life stages (early years, adolescence and mature adults) and in two priority groups (looked-after and accommodated young people and prisoners).

She led the NHS Board through an update on progress made against the priorities for action, explaining that most of the work was still in progress so the report included only examples of activity in key areas identified for action. She described innovative models of financial inclusion for families, work with authorities on tackling poverty, mental health promotion for young people, the legacy of Keep Well, information on the needs of looked-after children and young people, and health improvement of offenders. She cited some examples of the work in progress as follows:-

- Supporting NHSGGC's most disadvantaged families – looking at ways to better support frontline staff, strengthen involvement in advocacy and develop innovative new schemes to help people maximise their incomes by putting patients in touch with a team of money advice workers known as income maximisers.

- The transition of adolescence.

- Promoting healthy ageing.

- "Getting it Right for Looked-after Children and Young People".

- Improving health in NHSGGC's Prison Service.

Dr de Caestecker was delighted that progress had been made in all of the priorities for action and reported that further updates would be provided in the 2015 Director of Public Health report.

Director of Public Health

Dr Lyons welcomed the report and the associated actions. He raised two points which fitted in with the broad themes and where, he considered, further action was required, firstly, young people entering working age and, secondly, healthy ageing and the need to have a healthy older population. He also cited the obesity and alcohol consumption problems faced by the NHS. Dr de Caestecker agreed and confirmed that obesity and alcohol consumption were issues discussed within the chronic disease management protocols. There were a number of programmes available within NHSGGC to target both and she referred also to wider societal changes that needed to take place to target these areas such as the pricing of healthier food options and the pricing and availability of alcohol. Both were being discussed at a national level and she also referred to work she did locally with licensing boards.

Councillor Macmillan recorded his thanks and appreciation to Dr de Caestecker for her contribution to tackling poverty in Renfrewshire.

Councillor Rooney asked about the concept of "income maximisers" and Dr de Caestecker explained that they provided advice and help to families on how to get the most out of their income with the aim of improving their long-term health. They also provided advice on reducing debt payments or helped to change service tariffs. What was initially a project aimed at pregnant women and families with young children, "Healthier,Wealthier Children", had now expanded to provide the same support to people affected by a number of health issues. In terms of access to these income maximisers, that depended on the setting but she encouraged people to attend, in the first instance, local financial inclusion projects for referral.

In response to a question from Mr Robertson, Dr de Caestecker confirmed that, with the introduction of Health and Social Care Partnerships in 2015, it was her intention to provide her future DPH report in a different format. There would be a chapter looking

at the whole of NHSGGC and, thereafter, a chapter for each Health and Social Care Partnership. **Director of Public Health**

NOTED

100. RESPONSE TO THE VALE OF LEVEN HOSPITAL INQUIRY REPORT – IMPLEMENTATION OF RECOMMENDATIONS

A report of the Chief Executive [Board Paper No 14/64] asked the NHS Board to approve the process to submit, to the Scottish Government Health Directorate by 19 January 2015, the progress made in implementing the 65 NHS Board recommendations from the Vale of Leven Hospital Inquiry report.

At the outset, Mr Calderwood recorded his personal apology in respect of the shortcomings identified in the Vale of Leven Hospital Inquiry report. He acknowledged that there had been a failure at the hospital which he profoundly regretted and provided assurances that, as a result of the lessons learned, could not happen again. The NHS Board had approached the families who had submitted legal claims and had made a formal offer to settle the outstanding claims, and negotiations with the families' solicitors were ongoing.

The Chairman had asked the Chief Executive and appropriate directors to review the statements made by Lord MacLean in relation to individual members of staff and to also consider all subsequent steps taken since 2008 in relation to the actions of staff at that time. That review was now currently underway and would have Non-Executive Director involvement in the process and outcome.

Mr Calderwood explained that the Scottish Government Health Directorate had set up a process to monitor each NHS Board's assessment and implementation against the 65 recommendations identified for NHS Boards. He led the NHS Board through the guidance note and template that had been provided and explained that he would be required to describe the current position/progress towards implementing the recommendations and, where relevant, provide supporting evidence and examples of good practice.

He was then required to sign and return NHSGGC's template to the Scottish Government Health Directorate by 19 January 2015. Given this, it was recommended that a final draft be submitted to NHS Board Members by email on 13 January 2015 for comment. Once completed, it would be submitted to the Scottish Government Health Directorate by 19 January 2015 and the finalised template would then be submitted to the Quality and Performance Committee at its meeting on 20 January 2015 for endorsement.

In response to a question from Councillor Rooney, Mr Calderwood reported that, over and above the recommendations made in the Vale of Leven Hospital Inquiry report, the previous Cairns Smith report had highlighted recommendations which had been implemented. Cairns Smith had also met with the families as had the previous and current Cabinet Secretaries for Health and Wellbeing.

Mr Finnie expressed his disappointment at comments made in the editorial section of the Herald newspaper when the report was launched. He was keen to ensure a full response was given to each recommendation contained within the report. Mr Calderwood explained the approach taken by the NHS Board in that it issued a statement immediately to ensure that members of the public understood that NHSGGC's hospitals were a safe environment. In terms of assessment and implementation against the 65 recommendations, Mr Calderwood highlighted that many had already been implemented since September 2008 and, in responding to

others, he recognised that some would require a generic approach and some more governance-led.

DECIDED

- That, the process to submit to the Scottish Government Health Directorate by 19 January 2014 the progress made in implementing the 65 NHS Board recommendations from the Vale of Leven Hospital Inquiry report be approved. **Chief Executive**

101. DONATION OF SURPLUS EQUIPMENT

A report of the Interim Director of Finance [Board Paper No 14/65] asked the NHS Board to consider requests to donate surplus equipment to charitable organisations and, if so, note the proposed governance process for this.

Mr Hobson explained that, when services migrated to the new South Glasgow University Hospitals in 2015, existing equipment would be transferred where appropriate. Equipment not transferring would be redeployed to alternative sites or services where possible. Any remaining equipment may be declared surplus and disposed of. The NHS Board had received a number of requests from charitable organisations to donate NHS assets which had been identified as surplus to requirements. NHSGGC had previously received a formal submission from the Malawi Initiative, had considered this and supported it as an agreed strategy. This allowed the Malawi Initiative first call on such equipment and for the NHS Board to sanction any loss of potential income as a charitable donation. Subsequent requests had been received to donate equipment to Kenya, Syria and Zambia.

Mr Hobson outlined how the disposal of surplus assets was governed by the NHS Board's Standing Financial Instructions. These stipulated that, where an asset had been declared surplus to requirements, it must be disposed of for the maximum possible disposal proceeds or alternatively, the cost of disposal should be minimised. In order to maintain appropriate governance arrangements over the disposal of surplus assets to charitable organisations, he outlined the proposed process. This would not apply to surplus IT equipment for reasons of information governance. Any other device or equipment that had data storage or information processing capability must have all data removed prior to disposal. Data removal would be recorded by Medical Physics in the equipment record.

DECIDED

- That, surplus assets should be made available to charitable organisations which were registered with the Office of the Scottish Charity Regulator (OSCR) or an equivalent organisation be approved. **Interim Director of Finance**

- That, the proposed governance processes be noted.

102. BOARD PROPERTY TO BE DECLARED SURPLUS

A report of the Head of Capital Planning and Procurement [Board Paper No 14/66] asked the NHS Board to note the progress towards the disposal of four sites and that marketing arrangements for these properties would be progressed.

Mr Curran reported that, following a meeting of the Property Committee on 26 November 2014, as part of the NHS Board's continuing programme of rationalisation of its estates, four premises were to be declared surplus to requirements as follows:-

- Whittinghame Gardens Day Hospital, Great Western Road, Glasgow;
- Eastwood Resource Centre, 38 Seres Road, Clarkston;
- Maryhill Health Centre, 41 Shawpark Street, Glasgow;
- Clarkston Clinic, 56 Busby Road.

He reported that the first stage in the disposal process was to declare the properties surplus to requirements. Such a declaration would permit the property to be trawled in line with the NHS Property Transactions Handbook and ready the sites for marketing for sale.

NOTED

103. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Officer, Acute Services Division [Board Paper No 14/67] asked the NHS Board to note progress against the national targets as at the end of October 2014.

Ms Harkness led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times - 18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. She also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Ms Harkness alluded to fourteen ophthalmology and 243 neurology patients waiting over 12 weeks at the end of September 2014. At the end of October 2014, there were two ophthalmology, two dermatology and 110 neurology patients waiting over 12 weeks. She summarised various actions being taken over recent months to improve performance in these areas, highlighting the significant demand and capacity pressures in these specialties – she added that this was a national issue and not limited to NHSGGC.

Councillor Rooney asked about the cost of NHSGGC's unavailability policy whereby it continued to seek to provide patients with access to their nearest hospital, where at all possible, and accepted patient requests to wait to be treated at their choice of hospital/by their choice of consultant. Mr Calderwood explained that this had the effect of removing these patients from the waiting times guarantee and that, with access to nine acute hospital sites, NHSGGC patients were often eligible to be treated at a range of sites, thus making patient choice an option that may not be available in other Boards. He conceded that, going forward, it would be more difficult for NHSGGC to sustain that "choice factor" for patients. In response to his follow-up question concerning the Change Fund ceasing from April 2015, it was reported that it would be replaced by integration funds which would initially be for one year and this would assist with plans to continue to reduce bed days lost.

Dr Lyons welcomed the improvement on breast cancer performance due to improvement initiatives during the course of quarter 3 including the rapid improvement event for breast oncology. He referred to a recent English judgement concerning adults with incapacity which would result in implications for social work departments. He wondered if any horizon scanning was taking place in Scotland in light of this? Ms Harkness confirmed that she was aware of the judgement and that, in Scotland, guidance had been issued in terms of its likely impact.

Mrs Brown noted the information regarding patients awaiting discharge and was

concerned to see the increase in South Lanarkshire. Ms Renfrew agreed that this was disappointing and confirmed that attempts were being made to discuss this with NHS Lanarkshire as well as escalating it to the Scottish Government Health Directorate.

NOTED

104. FINANCIAL MONITORING REPORT FOR THE 7 MONTH PERIOD TO 31 OCTOBER 2014

A report of the Interim Director of Finance [Board Paper No 14/68] asked the NHS Board to note the financial performance for the first seven months of the financial year.

Mr Hobson reported that the NHS Board currently had an overspend of £1.3m for the seven month period to 31 October 2014. At this stage, however, the NHS Board forecast that a year-end break even outturn would be achieved.

He led the NHS Board through expenditure for the period as it related to Acute Services, NHS Partnerships, Corporate Services and other budgets and Capital. He confirmed that, at this stage, the NHS Board was close to its year to date cost savings target against plan.

Councillor Rooney referred to the decision made at the August 2014 NHS Board meeting to allocate £1.1m additional investment for unscheduled care – Mr Hobson confirmed that this was included in the report.

NOTED

105. QUARTERLY REPORT ON COMPLAINTS: 1 JULY TO 30 SEPTEMBER 2014

A report of the Nurse Director [Board Paper No 14/69] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 July to 30 September 2014 and note extracts from the ISD and SPSO Annual Reports 2013/14.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints handling performance of 82% of complaints responded to within 20 working days had been achieved.

Ms Crocket advised that a recording error had occurred in the Acute Services Division relating to the number of received and completed complaints. In correcting the method of validation, therefore, it had been necessary to amend the previous quarter's figures to reflect the accurate recording method. Apologies were given for this error which had now been rectified and, going forward, one single officer would complete the NHS Board quarterly returns and those submitted to ISD.

Ms Micklem welcomed the helpful and informative nature of the report. She referred to the online patient feedback system and asked about the proposed marketing campaign for this. Mr McLaws confirmed that a marketing campaign was planned for 2015 when the totality of ways which patients could provide feedback would be launched.

This was considered a more proactive and wider approach than marketing the online patient feedback system in isolation.

NOTED

106. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 16 SEPTEMBER 2014

The Minutes of the Quality and Performance Committee meeting held on 16 September 2014 [QPC(M)14/05] were noted.

NOTED

107. AREA CLINICAL FORUM MINUTES: 2 OCTOBER 2014

The Minutes of the Area Clinical Forum meeting held on 2 October 2014 [ACF(M)14/05] were noted.

NOTED

108. PHARMACY PRACTICES COMMITTEE MINUTES: 1 OCTOBER 2014 AND 10 OCTOBER 2014

The Minutes of the Pharmacy Practices Committee meetings held on 1 October 2014 [PPC(M)14/05] and 10 October 2014 [PPC(M)14/06] were noted.

NOTED

109. AUDIT COMMITTEE MINUTES: 25 NOVEMBER 2014

The Minutes of the Audit Committee meeting held on 25 November 2014 [A(M)14/05] were noted.

NOTED

110. CLOSING REMARKS

The Chairman wished all members and those in attendance a very merry Christmas and best wishes for 2015.

The meeting ended at 12:10pm

NHSGG&C(M)15/02
Minutes: 05 - 20

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 17 February 2015 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong (To Minute No: 15)
Dr C Benton MBE
Mr J Brown CBE
Ms M Brown
Mr R Calderwood
Dr H Cameron
Ms R Crocket MBE
Councillor M Cunning (To Minute No: 16)
Mr P Daniels OBE
Dr L de Caestecker (To Minute No: 16)
Councillor M Devlin
Professor A Dominiczak (To Minute No: 16)
Mr R Finnie
Mr I Fraser
Councillor A Lafferty
Mr I Lee
Dr D Lyons
Mrs T McAuley OBE
Councillor M Macmillan
Councillor J McIlwee
Ms R Micklem
Councillor M O'Donnell
Dr R Reid (To Minute No: 16)
Councillor M Rooney (To Minute No: 17)
Rev Dr N Shanks (To Minute No: 15)
Mr D Sime
Mr K Winter

IN ATTENDANCE

Mr J Best	Sector Director – North Sector (Acute Services Division)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr J Hobson	Interim Director of Finance
Dr I Kennedy	Consultant in Public Health Medicine (For Minute No: 13)
Mr D Leese	Chief Officer Designate, Renfrewshire IJB
Ms S McCorry-Rice	Director, North-West Glasgow Sector – Glasgow CHP
Mr A McLaws	Director of Corporate Communications
Ms K Murray	Chief Officer Designate, East Dunbartonshire IJB (To Minute No: 16)
Ms C Renfrew	Director of Corporate Planning and Policy

ACTION BY

05. WELCOME AND APOLOGIES

Mr Robertson welcomed Mr J Brown CBE to his first NHS Board meeting.

No apologies for absence were intimated.

NOTED

06. DECLARATION(S) OF INTEREST(S)

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

NOTED

07. CHAIR'S REPORT

(i) Mr Robertson had acknowledged receipt of a petition prior to the NHS Board meeting from the Royal College of Nursing (RCN). The petition, signed by 7,000 people, stated:-

"*The new South Glasgow Hospitals site is the largest in the country and a great asset for Glasgow. However, if staff cannot get to or park at the site, then patient care may be affected. Read more about the problems staff will face getting to and from work on time and safely at the new site on the RCN website.*

I ask that Glasgow City Council and NHS Greater Glasgow and Clyde resolve significant car parking and travel problems so I and my colleagues can get to work at the new South Glasgow Hospitals".

The Chief Executive would comment on that issue in his update to the NHS Board.

(ii) On 16 December 2014, the Cabinet Secretary for Health and Wellbeing visited staff at Glasgow Royal Infirmary to follow up on recommendations made in a recent Healthcare Environment Inspectorate (HEI) unannounced inspection. This provided an opportunity for good interaction with staff and the chance to outline the various follow up actions being made.

(iii) Also on 16 December 2014, Mr Robertson attended the Excellence in Education awards ceremony and with Professor A Dominiczak, presented awards to NHSGGC's senior medical colleagues who contributed to the education of NHSGGC's clinicians.

(iv) On 12 January 2015, the interviews for the Chief Officer post at Renfrewshire Health and Social Care Partnership took place. Mr Robertson confirmed that the successful candidate was Mr D Leese.

(v) Between 15 January 2015 and 16 February 2015, Mr Calderwood and Mr Robertson had had several meetings with the Cabinet Secretary for Health and Wellbeing and Scottish Government officials to discuss the 2020 Vision and the operational practicalities to achieve that at local NHS Board level.

(vi) On 21 January 2015, Mr Robertson hosted a visit from Mr J Swinney, Deputy First Minister, at the South Glasgow University Hospitals campus.

(vii) On 22 January 2015, Mr Robertson attended a meeting of the NHSGGC Primary Care Deprivation Group to discuss, amongst other things, the high level of satisfaction they had with the flexibility afforded in the 17c contracts.

(viii) On 23 January 2015, the interviews for the Director of Finance post were held and Mr M White had been appointed.

(ix) On 3 February 2015, Mr Robertson and Ms Crocket visited dementia services at Lightburn Hospital.

(x) On 5 February 2015, Mr Robertson and Mr Calderwood were guests at the Scottish Enterprise Life Sciences dinner. NHSGGC, the University of Glasgow and partners, ThermoFisher and Aridhia, were awarded with a major life sciences award in the "innovative collaboration" category.

(xi) On 9 February 2015, Mr Robertson spoke at an event in the City Chambers called "Improving the Cancer Journey", which brought together the NHS, the Council and third sector organisations led by Macmillan Cancer Care.

(xii) On 16 February 2015, the shortlisting for the post of Director of Human Resources took place.

(xiii) Mr Robertson referred to the imminent retiral on 31 March 2015, of two NHS Board Members, Dr C Benton MBE and Mr P Daniels OBE. Both had served an eight year period on the NHS Board and he referred to their tremendous contribution and insightful comments, not only at NHS Board meetings but at CH(C)P meetings and Pharmacy Practices Committee meetings. Both brought knowledge and clarity to many aspects of the work of the NHS Board and he recorded his appreciation and many thanks.

NOTED

08. CHIEF EXECUTIVE'S UPDATE

(i) Mr Calderwood referred to the petition received by Mr Robertson prior to the NHS Board meeting and advised that the new South Glasgow University Hospitals site and surrounding area was already serviced by 50 buses on an hourly basis. This information had been relayed to staff in a number of ways including transport roadshows, ongoing internal communications and orientation packs for staff working at the new hospitals. Through consultation with staff, shift patterns of staff due to work at the hospitals had been tailored to maximise access to transport options.

More than 10,000 staff would work on the new South Glasgow University Hospitals site when it was fully operational. The car parking capacity, however, must not exceed 3,500 parking spaces, a figure determined by Glasgow City Council as part of the Town and Country planning process. When the hospital buildings were operational, there would be 2,500 spaces available, with a further 1,000 spaces to be opened by the summer of 2016 on completion of a third multi-storey car park. NHSGGC was in continued dialogue with planners to look at whether there was any scope to increase the number of spaces from 3,500 to 4,000 as part of the final master planning of the site.

The NHS Board's Car Parking Policy was designed to ensure there was a balance in parking provision to meet patient and visitor parking requirements as well as staff. Permits were only issued to staff who worked across sites or performed a specialist role. The Car Parking Policy operated from Monday to Friday between 8am and 5pm, meaning that staff working at night and at the weekend could continue to park on site, as was the case at the moment.

The number of spaces NHSGGC could provide was regulated nationally by the Campus Carbon Sustainability Plan and the Green Travel Plan (all part of the planning application process). NHSGGC was investing £5.2m as part of the detailed Travel Plan which would improve accessibility to the new South

Glasgow University Hospitals campus. Improved public transport routes, traffic controls in the surrounding area and upgrading works to the local road network were all being implemented. The NHS Board was continuing to work closely in partnership with Strathclyde Partnership for Transport and Glasgow City Council to ensure that the investment was targeted at communities where there was currently insufficient public transport. The Scottish Government was also investing £40m in a new Fastlink scheme which, for the first time, would see direct transport from three main sites in the City Centre (Buchanan Street Bus Station, Queen Street and Central Stations) to the new South Glasgow University Hospitals campus. In addition, NHSGGC had submitted a further planning application with the City Council to increase the car parking capacity by a further temporary circa 600 spaces. Mr Calderwood hoped that this would be considered shortly, and, if approved, would assist with the provision of car parking for staff with permits.

(ii) On 29 December 2014, the First Minister and Cabinet Secretary for Health and Wellbeing visited staff and survivors of the bin lorry tragedy at Glasgow Royal Infirmary.

(iii) On 15 January 2015, Mr Calderwood was a guest at the launch of the University of Strathclyde's International Public Policy Institute.

(iv) Throughout January 2015, Mr Calderwood had visited all of NHSGGC's Accident & Emergency sites given the significant pressures identified there. He had debated with clinicians and Directors how to align resources and maximise care and safety for patients.

In response to a question from Councillor Rooney, Mr Calderwood reported that the bed model for 2015/16, alongside the NHS Board's Acute Services Strategy, saw a reduction in elective beds but an increase in unscheduled care beds.

The NHS Board asked Mr Calderwood to clarify the role of the Support Team (appointed by the Scottish Government) to work with the Royal Alexandra Hospital (RAH), Paisley, to help improve performance in Accident & Emergency (A&E). Mr Calderwood explained that, from 16 February 2015, unscheduled care managers from the Scottish Government would be working with the hospital to identify immediate measures and key actions to support improvements. NHS Scotland Chief Executive, Mr P Gray, had recognised the challenging winter for A&E departments across Scotland and apologised to patients who had waited longer than they should to have been seen and treated. He recognised that all staff had been working extremely hard to ensure patients got the best possible care, however, he was concerned that performance was not recovering as quickly as it should at the Royal Alexandra Hospital. Through performance monitoring and management, he had, therefore, provided support to the NHS Board to help ensure patients were seen and treated in A&E within the appropriate timescale. As such, he had provided specialist support to work with NHSGGC to deal with the current level of demand. This action would help identify issues where they existed and prioritise actions that could be taken to improve A&E performance.

Mr Calderwood added that the Scottish Government would be working closely with the NHS Board throughout this process to ensure that performance improvements were sustainable. There had been a lot of learning across Scotland in recent months about various different approaches to improving efficiency of patient flows in A&E departments and Mr Calderwood was hopeful that some of this learning may prove to be appropriate for the RAH to help local teams on the ground to deliver improved performance in the weeks and months ahead. He reiterated that the NHS Board and staff remained committed to

meeting the highest levels of service provision for patients and every opportunity to improve current challenged performance was welcomed.

Members remained concerned about how NHSGGC was informed about this decision and as to why a Support Team was being sent to the RAH in particular. Mr Calderwood confirmed that he had ensured that NHS Board Members became aware of the situation as soon as was possible. He added that the Support Team had met on 16 February 2015 and he had since received details of the members of the Team which would be circulated to the NHS Board. The Team was expected to produce a report by 2 March 2015 for the Cabinet Secretary of Health and Wellbeing and, as soon as this was available, he would also share this with the NHS Board. **Chief Executive**

In the interim, Mr Calderwood explained he would be restructuring the senior management team for "Clyde" and would bring forward the Interim Hospital Director appointment in advance of a substantive appointment being made. He also explained that learning from the Support Team and their work at the RAH would be rolled out across NHSGGC.

The NHS Board agreed to await the publication of the Team's report on 2 March 2015 (which would hopefully be received in time to be discussed at the NHS Board's Away Day on 9 March 2015) and discuss further how to proceed with the Scottish Government in terms of the resultant sequence of events. **Chairman**

Councillor Macmillan referred to the petition received earlier by Mr Robertson and extended these concerns to all hospitals not just the new South Glasgow University Hospitals. He highlighted the importance in continuing to engage with all staff in terms of parking provision at all hospital sites.

NOTED

09. MINUTES

(a) On the motion of Mr D Sime, seconded by Dr D Lyons, the minutes of the NHS Board meeting held on Tuesday, 16 December 2014 [NHSGGC(M)14/06] were approved as an accurate record and signed by the Chair.

(b) On the motion of Mr I Lee, seconded by Dr R Reid, the minutes of the NHS Board meeting held on Tuesday, 20 January 2015 [NHSGGC(M)15/01] were approved as an accurate record and signed by the Chair subject to the following amendments:-

- Minute No 03(a), 2nd paragraph, *delete* last sentence "He also commended the work of the current NHS Chair of the Community Health Care Partnership (CH(C)P)". *Insert*: "He also commended the joint collaborative approach he had experienced in working with the current NHS Vice Chair of the Community Health Care Partnership (CH(C)P)".

- Minute No 03(c), delete 3rd paragraph and insert the following new paragraph:-

  "Mr Sime referred to Section 10 of the draft and reported that the Area Partnership Forum's comments had largely been incorporated into the draft. However, in paragraph 10.2, the draft equated the NHS Board's Staff Governance Committee to the Council's Staff Representative Forum

when they were obviously not equivalent. It would be desirable to amend the draft appropriately in relation to Staff Governance and the linkages to the Area Partnership Forum on an equivalent basis to the Council's Staff Representative Forum". **Director of Corporate Planning & Policy**

- Minute No 03(d), delete 3rd paragraph and insert the following new paragraph:-

  "Mr Sime welcomed paragraphs 9.2 to 9.4 referencing workforce governance. However, like the Inverclyde Scheme, the draft contained the same issues of equivalence. It would, therefore, be desirable to amend the Glasgow City draft appropriately in relation to staff governance and the linkages to the Area Partnership Forum on an equal basis to the Council's Joint Consultative Forum". **Director of Corporate Planning & Policy**

- Minute No 03(d), 4th paragraph, "Dr Benton asked about the future of "hosted services....." change to read "Dr Benton asked about the future of "hosted services *including learning disabilities*.....".

NOTED

10. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted.

NOTED

11. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 15/03] asked the NHS Board to note an update on the Maternity and Children Quality Improvement Collaborative (MCQIC) which encompassed the clinical improvement activity of the SPSP's Maternity, Neonatal and Paediatric strands. Its overall aim was to improve outcomes and reduce inequalities in outcomes by providing a safe, high quality care experience for all women, babies and families in Scotland.

Ms Crocket reported that MCQIC was launched formally as a collaborative in March 2013 (a paediatric workstream had been active prior to that) and was a programme of quality improvement that would run until December 2015.

Ms Crocket described some of the key MCQIC events that had taken place and led the NHS Board through an update on the maternity workstream and the paediatric and neonatal workstream as follows:-

- Maternity Workstream – The maternity care strand aimed to support clinical teams in NHSGGC to improve the quality and safety of maternity healthcare. There were three major obstetric care sites in NHSGGC and they continued to make good progress in implementing the programme. The MCQIC Midwifery Champion roles were nationally funded and this funding ended in July 2015. A review of the support arrangements to consider the post-champion model was underway. The Directorate was also undergoing a revision of its governance structures within obstetrics and the role of MCQIC was a key feature of this. Ms Crocket highlighted some examples of the progress against each individual measure for the Southern General Hospital, Royal Alexandra Hospital and Princess Royal Maternity Unit.

- Paediatric and Neonatal Workstream – Its aim was to achieve a 30% reduction in adverse events that contributed to avoidable harm in neonatal and paediatric services by December 2015. There were currently 20 teams supported across paediatric and neonatal services.

In response to a question from Mr Robertson concerning the main aim of the paediatric and neonatal workstream, Ms Crocket acknowledged that to achieve a 30% reduction was a challenge. Given progress so far, however, she was hopeful this would be achieved.

Dr Lyons asked about tables 2 and 3 and, in particular, the use of Situation, Background, Assessment and Recommendation (SBAR). Ms Crocket reported that SBAR was a way of transferring critical information about patients. The tables reflected where teams currently were, and the Clinical Governance Unit Support Team was linking with the neonatal and paediatric service to consider how best to implement SBAR and align it to the current frontline team methods for data collection and reporting. It had been agreed that a monitoring group would review and sign off the quarterly SBAR reports prior to submission.

Ms Micklem commended the collaborative approach taken with both these workstreams but wondered how the inequalities element would be measured. Ms Crocket agreed that both workstreams were process and clinically driven so it was difficult to measure inequalities particularly when the aims were to provide a safe, high quality care experience for ***all*** women, babies and families across maternity care settings in Scotland – that was regardless of whether someone was in one of the protected characteristic groups or not. She agreed with Ms Micklem that the measurement of this particular aspect of the aim had to be considered further. **Nurse Director**

In response to a question from Dr Reid regarding one of the aims to "reduce the incidence of non-medically indicated elective deliveries prior to 39 weeks gestation by 30%", Ms Crocket reported that in NHSGGC, most elective deliveries related to the woman's and/or child's health. In order to meet this aim, she agreed that it would be useful to look at comparative data with other NHS Boards. **Nurse Director**

NOTED

12. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/04] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs). For the last available reporting quarter (July to September 2014), NHSGGC reported 24.1 cases per 100,000 AOBDs. NHS Scotland reported 32.3 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, July to September 2014, NHSGGC reported 33.8 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 39.7 per 100,000 AOBDs.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,214 members of staff who were now registered as Cleanliness Champions.

Ms Crocket led the NHS Board through the progress made following the Healthcare Environment Inspectorate (HEI) unannounced inspections at Glasgow Royal Infirmary in October 2014. She summarised the eight requirements and one recommendation resulting from these inspections.

Mrs McAuley asked about the C.Diff incidence rates and Dr Armstrong expected that, each quarter, these would fluctuate. She highlighted, however, that NHSGGC's rates were lower than the average rate for the rest of NHS Scotland. Every case of C.Diff was reviewed thoroughly to understand any local linkages with other cases and to explore further GP prescribing patterns.

With regard to the community hospitals report card, Dr Lyons referred to the MRSA, MSSA and C.Diff numbers and asked whether these had presented at one particular community hospital. Dr Armstrong described the upper and lower control limits that existed within each hospital (including community hospitals) and reported that the rates would not be specific to one hospital. She agreed to share the actual figures with Dr Lyons. **Medical Director**

In response to a question from Dr Benton regarding dress code and staff uniform compliance, Ms Crocket reported that Senior Charge Nurses had a responsibility on every shift to check and record compliance. This included junior doctors and she agreed it was paramount to keep reinforcing the message locally.

NOTED

13. EBOLA – UPDATE ON CONTINUING PREPAREDNESS ACTIVITIES AND HANDLING OF A CONFIRMED EBOLA CASE

A report of the Director of Public Health [Board Paper No 15/05] asked the NHS Board to note the Ebola preparedness activities undertaken by the NHS Board over the past six months and support ongoing activities which would further enhance this as well as public safety in the extremely low likelihood of further confirmed cases.

Dr de Caestecker described the background to the current Ebola crisis and the major international effort to control the outbreak, including nearly 2,000 personnel from the UK, which had resulted in first slowing, and more recently, a decrease in new cases.

She led the NHS Board through NHSGGC's preparedness plans to deal with any outbreak or individual who presented with an infectious disease. These plans were well-rehearsed in 2014 in preparation for the Commonwealth Games. She also summarised NHSGGC's response to an Ebola positive case in Glasgow in late

December 2014.

In summarising ongoing activity in NHSGGC, Dr de Caestecker reported that, given the trends and incidence and the commencement of Phase 2 clinical trials of Ebola vaccines in West Africa, it was becoming increasingly likely that the outbreak would be brought under control during 2015. Given that, it was anticipated that the activity required within NHSGGC to ensure preparedness would begin to taper off over the next 3-6 months. Many of the Ebola preparedness activities applied to other potential risks. In summary, over the past six months, significant work had been done to ensure NHSGGC was prepared for Ebola. The handling of the confirmed Ebola case demonstrated the success of that work though opportunities for further improving the response had been identified. These activities had improved the preparedness and resilience of NHSGGC, not just for Ebola, but more generally.

Mr Sime recorded his appreciation to all staff who had been, or had requested, to be deployed to help tackle Ebola and to the teams from across NHSGGC, particularly the Brownlee Unit, for the handling of the confirmed Ebola case. He reported that Dr Kennedy had attended the Area Partnership Forum meeting in December 2014 to provide an update on ongoing activities.

In response to questions from Dr Benton, Dr Kennedy confirmed that it was difficult to compare statistical information on Ebola as some countries reported cases as being "probable" whilst others reported "confirmed" only. He added that engagement with local communities was a priority and that a vaccine was not yet commercially available.

DECIDED

- That thanks to the teams from across the NHS Board, particularly the Brownlee Unit, for the handling of the confirmed Ebola case, be recorded. **Director of Public Health**
- That the Ebola preparedness activities undertaken by the NHS Board over the past six months be noted. **Director of Public Health**
- That the ongoing activities which would further Ebola preparedness and public safety, in the extremely low likelihood of a further confirmed case, be supported. **Director of Public Health**

14. APPROVAL OF SCHEMES OF INTEGRATION – INTRODUCTORY PAPER

A report of the Director of Corporate Planning and Policy [Board Paper No 15/06] asked the NHS Board to approve the Integration Schemes for Renfrewshire and East Dunbartonshire to provide a basis to move the two draft Integration Schemes into the next phase of process which was submission to the two respective Councils and then to Scottish Ministers for their approval. Once that approval was granted, Integrated Joint Boards (IJBs) could be established by Order of Scottish Ministers.

Ms Renfrew also sought to agree an approach to resolve the role for the IJB in oversight of local NHS Children's Services within the East Dunbartonshire Council area.

Ms Renfrew led the NHS Board through the introductory paper which set the context for the draft Integration Schemes which were the formal step required by legislation to establish the new IJBs. These had been developed in a process led by each Chief Officer and an important point of that context was that, for the NHS Board, the planning and service responsibilities which would be discharged by IJBs remained part of a whole NHS system for NHSGGC.

Ms Renfrew described NHSGGC's approach to operational delivery, the essence of which was that the Chief Officer would carry that responsibility with oversight and direction provided by the IJB. The Service Delivery Framework attached to the NHS Board paper had been drafted to ensure a clear basis for delegation and assurance about the lines of sight back to the NHS Board's statutory responsibilities for governance across clinical quality and safety, staff and employment, equalities and finance. That Framework had been finalised following further discussion with Directors and Chief Officers.

Ms Renfrew reported that Renfrewshire and East Dunbartonshire Councils had both not included Children's and Criminal Justice Services which were included in NHSGGC's other four Schemes but were discretionary under the legislation. The NHS Board had proposed including planning and delivery of local NHS Children's Services within its proposals for the Chief Officer role and IJB oversight. In the case of East Dunbartonshire Council, there had not been agreement that the IJB would fulfil the functions of oversight and direction for these responsibilities. From the health perspective, there were clear benefits to integrated local oversight for local Children's Services and it was not clear what alternative arrangements the NHS Board could establish. To try to reach agreement, NHSGGC proposed promoting a discussion at the shadow IJB to inform a formal proposal to put to the Council and potentially for discussion with the IJB when established. The Scheme could be submitted with wording which enabled this issue to move forward in this way and commit neither party to the outcome.

The NHS Board discussed the circumstances of East Dunbartonshire Council's Children's Services and Criminal Justice Services. It was agreed that Ms Renfrew reword the Scheme to reflect the opportunity for these services to be added at a later date if this be agreed by both East Dunbartonshire Council and NHSGGC. This would allow Ministerial sign-off at this stage, but also afforded the opportunity for the services to be added developmentally in the future. Discussion would not be with the Shadow IJB but through a proposal put to the Council.

Director of Corporate Planning & Policy

The paper set out possible arrangements in the likely event that the Integration Schemes had not passed due process by 1 April 2015 at which point, the legislation which established CH(C)Ps was rescinded. The current CH(C)P Committees would be migrated to oversight Subcommittees of the NHS Board with the aim to try and find an approach which enabled Councillors who were part of the IJBs to be part of these arrangements.

Mr Robertson invited each Chief Officer Designate to lead the NHS Board through their draft Scheme of Integration as follows:-

(a) Renfrewshire
(b) East Dunbartonshire

(a) Renfrewshire Scheme of Delegation

Mr Leese, Chief Officer Designate, Renfrewshire Integrated Joint Board, led the NHS Board through the detail of Renfrewshire's draft Integration Scheme. He summarised activities that had taken place during the consultation phase between 19 January and 3 February 2015. He thanked NHS and Council colleagues for the significant amount of effort to reach this stage.

(b) East Dunbartonshire Scheme of Delegation

Mrs Murray, Interim Chief Officer, East Dunbartonshire Integrated Joint Board, led the NHS Board through the draft Integration Scheme and reported that a Council meeting of East Dunbartonshire was arranged for 5 March 2015 to similarly consider the draft Scheme. She summarised the formal public consultation undertaken in relation to the Scheme and outlined the IJB's Strategic Priorities.

DECIDED

- That, the Integration Schemes for East Dunbartonshire and Renfrewshire be approved:-

  - With authorisation to the Interim Chief Officers and Director of Corporate Planning and Policy to work together with Council colleagues to revise Schemes based on the NHS Board discussion and to engage with the Scottish Government to progress the Schemes' approval; **Director of Corporate Planning & Policy**

  - Should that approval process raise issues which could not be resolved, to report back to the NHS Board for further direction; " "

  - Endorse the final framework for Service Delivery; " "

  - A proposal be made by the NHS Board to East Dunbartonshire Council with regard to arrangements for children's services. " "

  - Confirm the direction of the proposed arrangements should IJBs not be in place from 1 April 2015. " "

15. DRAFT STRATEGIC DIRECTON AND LOCAL DEVELOPMENT PLAN 2015/16

A report of the Director of Corporate Planning and Policy [Board Paper No 15/07] asked the NHS Board to discuss work in progress to finalise the Strategic Direction and Local development Plan 2015/16 for submission to the Scottish Government by the end of March 2015.

Ms Renfrew explained that the NHS Board submitted a Local Development Plan (LDP) each year to outline how it would deliver against the Annual Planning Guidance issued by the Scottish Government. NHSGGC's approach was to develop the LDP as an integral part of finalising its strategic direction for 2015/16. She led the NHS Board through progress in developing this work in relation to the following:-

- The draft Strategic Direction and LDP;
- A draft of the current Financial Plan which had been submitted to the Scottish Government.

Ms Renfrew explained that this was still work in progress and summarised the work still required and the areas of activity needed to drive the decisions which would be necessary to deliver a balanced financial plan.

Ms Renfrew described the implications for the LDP process given that Integrated Joint

Boards (IJBs) would be in place from early in the new financial year with their new responsibilities for strategic planning of local services and substantial elements of unscheduled care. She also alluded to specific LDP requirements and provided a brief indication of NHSGGC's position in the following areas:-

- Health inequalities and prevention;
- Antenatal and early years;
- Person-centred care;
- Safe care;
- Primary care;
- Integration;
- Workforce;
- Community planning and partnership contribution.

At headline level, a major issue was the NHS Board's ability to deliver the targets and standards set within available resources and the NHS Board would need to assess, in financial planning, whether all of these targets could be delivered.

Mr Sime referred to the current appraisal of the financial position which showed a gap between NHSGGC's 2015/16 income and known costs of £48m. Mr Calderwood explained that, across Acute, Partnerships and Corporate Services, NHSGGC had, so far, identified around £32m of savings, establishing a gap of around £16m. Work was underway to identify further cost savings for 2015/16 and there may also be further cost pressures to cover, for example, additional costs for new drugs and for out-of-hours services.

Ms Brown referred to a proposal to assess, from the Paisley Development Programme, whether there were self-financing changes which could be made in Primary Care and the NHS Board's commitment to continue the development of the 17c programme with new practices joining in 2015/16. She did not think the NHS Board should restrict itself to looking at only self-financing changes and hoped that the NHS Board would work with IJBs to set out prioritised local actions that were being pursued to increase capacity in Primary Care and the resources identified to achieve this. Ms Micklem agreed and recognised the difficult decisions that had to be made looking at resource allocations in line with Scottish Government policy.

Director of Corporate Planning & Policy

Mr Winter acknowledged that the NHS Board faced a very challenging year and noted the savings that had to be made. Mr Calderwood described factors that would be explored, in greater detail, to release costs and confirmed that the NHS Board would continue to look at opportunities as well as redesign work and different service delivery models. Proposals were currently being worked up and they would be shared with the NHS Board.

Chief Executive

In response to a question from Ms Micklem regarding the financial gap, Mr Calderwood reported that he and colleagues continued to have dialogue with the Scottish Government, on a daily basis, and that all options would be explored. He reiterated that government policy determined the NHS Board's uplift and National Reserve Allocation Committee (NRAC) parity.

Dr Reid welcomed the inclusion in the Local Development Plan of how services would support positive care experiences delivered in accordance with the "five must-dos with me". This was an essential element of person-centred care and he looked forward to seeing how local action would be taken to transform the culture to support staff and the public to be open and confident in giving and receiving feedback.

DECIDED

- That, the work in progress to finalise the Strategic Direction and Local Development Plan 2015/16 be noted and submitted to the Scottish Government by the end of March 2015. **Director of Corporate Planning & Policy**

16. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Officer, Acute Services [Board Paper No 15/08] asked the NHS Board to note progress against the national targets as at the end of December 2014.

Mr Best led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times - 18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

In response to a question from Dr Lyons regarding stroke performance at the Royal Alexandra Hospital (RAH), Mr Best reported that the RAH had an unusually high number of patients missing just one of their required targets and this explained the particularly low performance – he reassured the NHS Board that action was being taken particularly with stroke scanning at the RAH over weekends. This work was being taken forward by the Rehabilitation and Assessment Directorate.

Professor Dominiczak referred to the current national difficulty in filling consultant neurologist vacancies and suggested that the University of Glasgow may be able to offer assistance from an academic point of view. Mr Best welcomed this offer and would discuss this further with her. **Chief Officer (Acute Services)**

Councillor Rooney referred to the Accident & Emergency waiting times and highlighted, in particular, the performance in December 2014 at the Western Infirmary (69%) and the Royal Alexandra Hospital (77%). He set this in the context of the Ministerial Support Team established to help at the RAH discussed earlier. Mr Calderwood took the opportunity to highlight that, as the Western Infirmary was scheduled to close in May 2015, there may be limited learning now from there. He recorded that staff were working well in the RAH and that there had been an issue with the flow of patients. He looked forward to working with the Support Team to have their insights into how performance could be improved.

Ms Brown welcomed the progress being made with patients awaiting discharge. In response to her request, Mr Best confirmed that he would include a report on the processes adopted for rapid improvement events and design initiatives so that improvements could be identified. She also encouraged the inclusion of patient involvement in the Ministerial Support Team. **Chief Officer (Acute Services)**

Dr Benton wondered if it would be possible to give a further breakdown of the reasons patients cite as being unavailable and, therefore, included in NHSGGC's unavailability rates. Mr Best confirmed that patient choice of consultant or hospital site was consistently the reason for approximately 50-70% of the total patient-advised unavailability. He agreed to add further information in future reports. **Chief Officer (Acute Services)**

Mr Calderwood went on to explain that other NHS Scotland Boards were strictly

interpreting the access provision and returning patients to the care of their GP if they had declined two reasonable offers. In line with the NHSGGC Access Policy, this practice had not been adopted and patients' preferences of admission date/site were consistently accommodated.

In response to a question from Members, Mr Calderwood agreed to share with the NHS Board information that had been provided about the Support Team, its members and what it set out to do.

Chief Executive

NOTED

17. FINANCIAL MONITORING REPORT FOR THE 9 MONTH PERIOD TO 31 DECEMBER 2014

A report of the Interim Director of Finance [Board Paper No 15/09] asked the NHS Board to note the financial performance for the 9 month period to 31 December 2014.

Mr Hobson reported that the NHS Board currently had an overspend of £0.7m for the 9 month period to 31 December 2014. At this stage, the NHS Board forecast that a year end break even outturn would be achieved.

He led the NHS Board through expenditure for the period as it related to Acute Services, Partnerships, Corporate Services and other budgets and capital. He confirmed that, at this stage, the NHS Board was ahead of its year to-date cost savings target against plan.

Referring to discussions earlier around the challenges that the NHS Board faced now and in the future, Mr Finnie took the opportunity to thank Mr Hobson and his teams for managing the NHS Board's financial performance.

In response to a question from Councillor Rooney about the additional funding allocation of £3.6m the NHS Board received from the Scottish Government to offset drug cost pressures in 2014/15, Mr Hobson confirmed that this was non-recurring.

NOTED

18. PATIENTS PRIVATE FUNDS – ANNUAL ACCOUNTS 2013/14

A report of the Interim Director of Finance [Board Paper No 15/10] asked the NHS Board to adopt and approve, for submission to the Scottish Government Health Directorates, the 2013/14 Patients Private Funds Annual Accounts for NHS Greater Glasgow and Clyde.

Mr Hobson advised that the NHS Board held the private funds of many of its patients, especially those who were in long term residence and who would have no ready alternative for the safe-keeping and management of their funds. Each of the NHS Board's hospitals had arrangements in place to receive and hold and, where appropriate, manage the funds of any patients requiring this service. Any funds that were not required for immediate use were invested to generate interest which was then distributed to the patients' accounts based on each individual's balance of funds held.

NHS Boards were required to submit audited annual accounts for these funds in the form of an Abstract of Receipts and Payments to the Scottish Government Health

Directorates. The funds had been audited and now required NHS Board approval prior to the auditors then signing their report, which had no qualifications.

DECIDED

1) That the Patients' Private Funds Annual Accounts for 2013/14 be adopted and approved for submission to the Scottish Government Health Directorates. **Interim Director of Finance**

2) That the Director of Finance and Chief Executive be authorised to sign the Abstracts of Receipts and Payments for 2013/14. '' ''

3) That the Chair and Director of Finance be authorised to sign the Statements of Board Members' Responsibilities for 2013/14. **Chair/Interim Director of Finance**

4) That the Chief Executive be authorised to sign the Letter of Representation to KPMG LLP on behalf of the NHS Board. **Chief Executive**

19. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 18 NOVEMBER 2014

The minutes of the Quality and Performance Committee meeting held on 18 November 2014 [QPC(M)14/06] were noted.

NOTED

20. AREA CLINICAL FORUM MINUTES: 4 DECEMBER 2014

The minutes of the Area Clinical Forum meeting held on 4 December 2014 [ACF(M)14/06] were noted.

NOTED

The meeting ended at 12:40pm.

NHSGG&C(M)15/03
Minutes: 12 - 30

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 21 April 2015 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr J Armstrong
Mrs S Brimelow OBE
Ms M Brown
Mr R Calderwood
Ms R Crocket MBE
Councillor M Devlin
Mr R Finnie
Mr I Lee
Dr D Lyons
Mrs T McAuley OBE
Mr A Macleod
Councillor M Macmillan (To Minute No 24)
Councillor J McIlwee
Ms R Micklem
Councillor M O'Donnell
Dr R Reid
Councillor M Rooney
Rev Dr N Shanks
Mr D Sime
Mr M White
Mr K Winter

IN ATTENDANCE

Mr G Archibald	Chief Officer, Acute Services Division
Dr E Crighton	Consultant in Public Health Medicine (For Minute No 20)
Ms J Erdman	Corporate Inequalities Manager (For Minute No 23)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr A McLaws	Director of Corporate Communications
Ms C Renfrew	Director of Corporate Planning and Policy
Mr R Wright	Director, Health Information & Technology

ACTION BY

12. WELCOME AND APOLOGIES

Mr Robertson welcomed Mrs S Brimelow and Mr A Macleod to their first NHS Board meeting as Non-Executive Members from 1 April 2015. Similarly, he welcomed Mr M White to his first NHS Board meeting since being appointed Director of Finance on 1 April 2015.

Apologies for absence were intimated on behalf of Mr J Brown CBE, Dr H Cameron, Councillor M Cunning, Dr L de Caestecker, Professor A Dominiczak OBE, Mr I Fraser and Councillor A Lafferty.

NOTED

13. DECLARATION OF INTEREST

One declaration of interest was recorded as follows:-

- Dr D Lyons, in respect of Item No 12 - Meeting the Requirements of Equalities Legislation – A Fairer NHSGGC: Monitoring Report 2013-15 – Dr Lyons was a member of the Equality and Human Rights Commission – Scotland Committee.

NOTED

14. CHAIR'S REPORT

(i) On 23 February 2015, the Cabinet Secretary for Health and Wellbeing, Shona Robison MSP, officially opened the new state-of-the-art Assisted Conception Service Centre at Glasgow Royal Infirmary. The Unit now provided a modern facility for assisted conception services for patients across NHSGGC, Ayrshire and Arran, Dumfries and Galloway, Lanarkshire and Highland Health Boards. On the same day, Ms Robison cut the first sod at a special ceremony to mark the construction of Eastwood Health and Care Centre in Clarkston. This new Health and Care Centre would serve the whole of the Eastwood area of East Renfrewshire and would house GP practices, district nursing, health visitors, social work, physiotherapy and podiatry services as well as mental health services. In addition, the Centre would be home to a Community Enterprise in the form of a cafe run as an employability project.

(ii) On 9 March 2015, NHS Board Members had attended an off-site day focusing on the moves to the new South Glasgow University Hospitals and financial planning 2015/16.

(iii) On 12 March 2015, Mr Robertson attended a volunteer thank you event at the Royal Alexandra Hospital in the form of a "Springtime Tea Party" to celebrate and thank all volunteers for their contribution.

(iv) On 24 March 2015, Ms A MacPherson was appointed as the Director of Human Resources and Organisational Development for NHSGGC to replace Mr I Reid. Her appointment would take effect from 1 June 2015.

(v) On 31 March 2015, Mr Robertson attended the 2015 Addiction Employability Graduation Ceremony held in the City Chambers.

(vi) On 1 April 2015, the Cabinet Secretary for Health and Wellbeing officially opened the Possilpark Health and Care Centre.

(vii) On 8 April 2015, Mr Robertson visited the 100 Flowers art collection in the new South Glasgow University Hospital. This recognised the benefit of having art work within the hospital areas and the collection could be seen in the Adult Hospital Cafe, Atrium, Interview Rooms and corridors.

(viii) On 9 April 2015, Mr Robertson attended a conference at the Lighthouse Glasgow, on "Lateral Thinking – the Value of Collaboration between the Arts, Health and Environment".

NOTED

15. CHIEF EXECUTIVE'S UPDATE

(i) Mr Calderwood updated on the organisational restructuring to the Senior Management Team as follows:-

- Director of Human Resources and Organisational Development – Anne MacPherson had been duly appointed and would start on 1 June 2015. She would work with the current Director of Human Resources, Mr I Reid, for a month prior to Ian's departure at the end of June 2015.

- Director of Nursing – Rosslyn Crocket had intimated her intention to retire at the end of August 2015. This post would be advertised next week.

- South Clyde Sector Director – Marie Farrell had been appointed and would be based at the Royal Alexandra Hospital.

- Director of Regional Services – Gary Jenkins had been appointed.

- The majority of General Manager appointments had now been made and steps would be taken to advertise the remaining General Manager posts.

- Director of Research and Development – A joint post with the University of Glasgow. Regrettably, following interviews on 9 April 2015, an appointment was not made. Mr Calderwood and Dr J Armstrong would consider how best to proceed to fill this important post.

(ii) On 9 April 2015, the NHS Board hosted a visit from representatives from the Danish Health Service who were on a fact-finding visit in relation to Acute Services Modernisation and Healthcare Premises. The cohort toured the new South Glasgow University Hospital and it provided an excellent opportunity to share knowledge with a different healthcare system.

(iii) Mr Calderwood reported that Monday 28 April 2015 would see the existing Outpatients Department from the current Southern General Hospital move into the new South Glasgow University Hospital. Thereafter, a rolling programme was in place to move patients into the new hospitals.

NOTED

16. MINUTES

On the motion of Councillor M Devlin, seconded by Councillor J McIlwee, the minutes of the NHS Board meeting held on Tuesday, 17 February 2015 [NHSGGC(M)15/02] were approved as an accurate record and signed by the Chair.

NOTED

17. MATTERS ARISING FROM THE MINUTES

(a) The Rolling Action List of matters arising was noted. Mr Macleod asked for an update on the NHS Board's Endowment Funds Strategy. Mr White summarised the work being taken forward to improve the NHS Board's degree of oversight and governance going forward to comply with the associated regulations. Dr R Reid would be the Chair of the Endowments Committee

going forward.

(b) Mrs McAuley asked for an update on the Schemes of Delegation for Glasgow City (in relation to Forensic Services and Children's Services) and East Dunbartonshire (in relation to Children's Services). Ms Renfrew reported that a resolution had been reached with Glasgow City Council and this would be considered further at the May 2015 Quality and Performance Committee meeting to finalise the arrangements for Forensic and Children's Services going forward. In relation to Children's Services in East Dunbartonshire, a paper was due to be considered by East Dunbartonshire Council imminently.

NOTED

18. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report by the NHS Board's Medical Director [Board Paper No 15/11] asked the NHS Board to note an update on the SPSP for Mental Health and Primary Care.

Dr Armstrong set out a broad description of the clinical processes being developed to operate with higher levels of reliability, the scope of testing work along with a brief outline of progress and challenges for both the Mental Health Services and Primary Care Services. She took each one in turn as follows:-

- Implementing SPSP in Mental Health Services – aimed to systematically reduce harm experienced by people receiving care from Mental Health Services in Scotland by supporting clinical staff to test, gather real-time data and reliably implement interventions. The work was being delivered through a four year programme running from September 2012 to September 2016. Within the programme, five national workstreams had been identified and Dr Armstrong summarised key activities in those areas as follows:-

  - Risk assessment and safety planning;
  - Communication at key transition;
  - Safe and effective medicines management;
  - Restraint and seclusion;
  - Leadership and culture.

  Dr Armstrong explained that, as with all major change programmes, there were many challenges and she alluded to those identified in the Mental Health programme including its scale, quality improvement capacity and capability, competing priorities for ward staff and finding a good balance between local innovation and the need to benefit from NHS Board-wide standardisation and integration of care. She reported that consultation with the National Programme continued to consider extending SPSP-MH to crisis teams and/or sexual harm over the next year.

- Implementing SPSP in Primary Care Services – the aim was to reduce the number of patient safety incidents to people from healthcare delivered in any Primary Care setting. All NHS Boards and 95% of Primary Care clinical teams were tasked with developing their safety culture and achieving reliability in three high risk areas by 2016. In addition, an NHSGGC Polypharmacy Local Enhanced Service had been developed regarding polypharmacy and quality, safe and effective use of long-term medication. A medicines reconciliation component had been built into this Local Enhanced Service using the bundle approach and measurement by reporting monthly compliance. 252 practices participated in this. Dr Armstrong summarised activity in the following areas:-

- General practice;
- Safety climate survey;
- Trigger tool;
- Leadership walkrounds;
- Polypharmacy Local Enhanced Service 2014-15;
- Core programme (small scale testing);
- Outpatient communication;
- Results handling;
- Medicines reconciliation;
- 5-step screening tool called Malnutrition Universal Screening Tool (MUST);
- Falls and Catheter Acquired Urinary Tract Infections (CAUTI).

In terms of Community Nursing, Ms Crocket explained that further work was being undertaken in the wider implementation and spread of the bundle approach in Community Nursing with areas identified for improvement to patient safety which included falls, CAUTI, MUST and the continuation of the prevention of pressure ulcer work. To date, work had focused on pressure ulcers and MUST as follows:-

- Pressure Ulcer Prevention – district nursing teams in NHSGGC had been participating in the SPSP Pressure Ulcer workstream for approximately 18 months. All teams were now achieving 100% compliance. Work would now be progressed via the Clinical Nursing Information System (CNIS) to allow outcome data to be extracted. This would reduce time spent on input for district nurses and reports could be generated at practitioner, Senior Nurse and Head of Service level, commencing May 2015.

- MUST – within this workstream, a bundle had been developed and was being tested in five district nursing teams. Teams had received training on the methodology being used and data collection was being established. Across the five teams, results had been varied but had progressed well and coped with the restructuring of the district nurse service in some of these areas.

Rev Dr Shanks reported that he had accompanied Dr Armstrong on some of the walkrounds and recognised the challenges, particularly with the competing priorities which staff faced. In highlighting this, he encouraged the NHS Board to support protected time to ensure staff could meet clinical demands and competing organisational priorities which could hamper continuous focus on this work in some areas. Dr Reid agreed and recognised the importance in having intuitive IT systems to support the programme and its monitoring.

Mrs Brimelow welcomed the helpful work being taken forward in community nursing but recognised that the spread across NHSGGC was a challenge. Ms Crocket agreed but explained that, although the key aim was to achieve 95% compliance by 2016, the principles of the programmes would be ongoing.

Ms Micklem referred to the pace of development in general terms for SPSP and considered it difficult to judge whether NHSGGC was moving at a pace expected. She would welcome a report outlining what was going to plan as well as what was not. Dr Armstrong agreed to review progress and report developments in future reports. Ms Crocket added that all SPSP activity was linked to the Compliance Assessment and Analysis System (CAAS) which allowed the measurement of compliance against standards and this was integral to the spread in a more rigorous way.

Medical Director

Councillor McIlwee asked about the Safety Climate Survey (Safequest) which had

been developed by NHS Education for Scotland (NES). Dr Armstrong reported that this was a very robust tool used currently in Primary Care – she agreed to explore whether it could be used also within Acute areas. **Medical Director**

In response to a question from Dr Lyons, Dr Armstrong agreed to check how SPSP was being evolved within areas that included older adults in mental health. **Medical Director**

NOTED

19. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/12] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs). For the last available reporting quarter (October to December 2014), NHSGGC reported 25.1 cases per 100,000 AOBDs. NHS Scotland reported 30.5 cases per 100,000 AOBDs. The revised national HEAT target required all NHS Boards in Scotland to achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

NHSGGC successfully achieved the 2013 Clodistrium Difficile HEAT target of less than 39 cases per 100,000 AOBDs in the over-65s age group. The new target for future attainment included cases in ages 15 and over and this was subsequently revised in 2013 by the Scottish Government following a change in the calculation of bed day data and now required NHS Boards to achieve a rate of 32 cases or less per 100,000 AOBDs to be attained by 31 March 2015. For the last available reporting quarter, October to December 2014, NHSGGC reported 33.3 cases per 100,000 AOBDs, combined rate for all ages. This placed the NHS Board below the national average of 35.4 per 100,000 AOBDs.

For the last available quarter (October to December 2014), the SSI rates for caesarean section and knee anthroplasty procedure categories were below the national average; repair of neck of femur procedures matched the national average and SSI rates for hip anthroplasty procedures remained above the national average.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 3,224 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong referred to a Healthcare Environment Inspectorate (HEI) unannounced inspection at the Royal Hospital for Sick Children on 16 and 17 December 2014 which had resulted in three requirements and one recommendation.

In response to a question regarding the decrease in MSSA between December 2013 and December 2014, Dr Armstrong reported that this represented 17.3% and much of its success could be attributed to the new bundle introduced by NHSGGC after a successful pilot at the RAH.

In response to a question from Councillor Rooney regarding the data used for the "Out of Hospital Report Cards" and "Hospital Report Cards", Dr Armstrong confirmed that these were monitored by the NHS Board's Infection Control Committee and she agreed to give Councillor Rooney a further breakdown of the data. **Medical Director**

In response to a question from Mrs Brimelow regarding the Vale of Level Hospital Inquiry Report, Dr Armstrong confirmed that NHSGGC had submitted its report on the implementation of the recommendations within the report to the Scottish Government, and that many of these linked with the HAI standards recently published. Compliance with the recommendations and the standards was considered by the NHS Board's Infection Control Committee and the Clinical Governance Forum. A summary of progress would be considered by the NHS Board's Quality and Performance Committee in the autumn. **Medical Director**

In response to a question from Mrs McAuley, Dr Armstrong reported that local analysis of recurring C.Difficile infections (relapse/reinfection cases) for January to December 2014 indicated a recurrence in 16% of patient cases and work was being undertaken to understand what lay behind this. Dr Armstrong added that this was a UK-wide issue, and local colleagues were working with Health Protection Scotland to identify patterns.

NOTED

20. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT 1 APRIL 2013 TO 31 MARCH 2014

A report of the Director of Public Health [Board Paper No 15/13] asked the NHS Board to note the Public Health Screening Programme Annual Report from 1 April 2013 to 31 March 2014.

Dr Crighton presented information about the following screening programmes offered to residents across NHSGGC for the period 2013/14:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
  - Communicable diseases in pregnancy
  - Haemoglobinopathies screening
  - Downs syndrome and other congenital anomalies
- New born screening:-
  - New born blood spot
  - Universal new born hearing
- Diabetic retinopathy screening
- Preschool vision screening
- Aortic abdominal aneurysm screening

Dr Crighton explained that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of serious conditions.

In NHSGGC, the co-ordination of all screening programmes was the responsibility of the Public Health Screening Unit led by a consultant in public health medicine. Multi Disciplinary Steering Groups for the programmes were in place and the remit was to monitor performance, uptake and quality assurance.

Dr Crighton highlighted that, as the screening programmes stretched across the whole organisation, successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. It was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered to NHSGGC residents.

NHSGGC's Public Health Screening Unit was committed to working in partnership with voluntary and statutory services to identify innovative ways to tackle inequalities in health and encourage uptake of screening programmes. The report included analysis in uptake among people with learning disabilities, however, screening activity by ethnicity could not be provided as the data was not available.

Dr Crighton commended the efficiency of the screening programmes and reiterated that they could prevent disease. She responded to a range of members' questions by confirming the following:-

- Recognition that the huge amount of activity ongoing to improve uptake rates and address inequalities was a priority in order to close the inequality gap. Campaigns were designed and developed with particular target groups/age groups in mind to ensure all had access to relevant screening programmes.

- Collecting screening activity by ethnicity remained a challenge and work was ongoing to identify lessons learned in the pregnancy and newborn screenings where screening activity by ethnicity data was available – how could this be rolled out across the other screening programmes?

- What was the success in uptake rates from national campaigns versus more locally targeted campaigns? If differences were identified in advertising approaches, perhaps lessons could be learned in how best to attract certain client groups?

- The enhanced governance and audit of interval breast cancer data was useful and this intelligence would now provide more detail going forward. Detecting cancer early remained a priority but making better use of the data now available around interval breast cancer would be explored further.

- Work continued to improve local and national IT systems to support the array of screening programmes.

- Abdominal aortic aneurysm screening was available to male residents aged 65 in NHSGGC who were invited to participate in the programme. Based on evidence, one scan was sufficient and this was the best way to detect the presence of an abdominal aortic aneurysm. Based on research, no evidence was apparent, at the moment, to suggest further screening thereafter.

- The benefits in attending for screening could be highlighted more in the national/local campaigns and it would be useful to showcase individual instances where lives had been saved due to attendance at screening. Various approaches to advertising the different screening campaigns was considered regularly in terms of target audiences. **Director of Public Health**

Mr Robertson, on behalf of the NHS Board, thanked Dr Crighton for her comprehensive summary of the Annual Report.

NOTED

21. ORGANISATIONAL REVIEW – PROPOSALS FOR FUTURE ORGANISATION OF CLINICAL GOVERNANCE

A report of the Medical Director [Board Paper No 15/14], asked the NHS Board to note the new clinical governance arrangements for NHSGGC following the new organisational structure within the Acute Services Division and with the implementation of the six Health and Social Care Partnerships (HSCPs).

Dr Armstrong described the current position in NHSGGC in that, the delegated role and responsibilities of the Quality and Performance Committee was currently responsible for maintaining oversight of the quality of care provided through NHS Board services, either directly or commissioned. This Committee, on behalf of the NHS Board, provided the internal assurance statements that NHSGGC was meeting the statutory duty of care set by the Health Act 1999. Over and above that, the existing Board Clinical Governance Forum was responsible for oversight and strategic coordination of priorities and programmes aimed at improving and assuring safe, effective, person-centred care. It oversaw the work of the Acute Clinical Governance Forum, the Partnerships Clinical Governance Forum and the Mental Health Clinical Governance Forum and there was an extended structure of clinical groups operating in support of these strategic forums.

The Clinical Governance Support Unit was created in 2005 and was a corporately provided facility to support clinical quality improvement and governance. The Unit was initially organised around two key specialist functions of clinical improvement and risk. Staffing/resources were linked to the three main organisational domains of support; Corporate, Acute and Partnerships.

Dr Armstrong led the NHS Board through the drivers for change, alluding to external and internal challenges and reported that the advent of HSCPs necessitated a complete review of governance arrangements. There was a requirement for HSCPs, through their governance arrangements, to establish formal structures to link with the clinical governance structures of the NHS Board as well as Local Authority governance structures. In order to progress overall arrangements, it was important that the clinical governance structures at NHS Board level were set out together with the different levels of reporting and assurance to reflect the areas where the NHS Board retained direct responsibility for services and areas where the responsibility would be delegated to Chief Officers.

Following clinical and management engagement, discussion papers were developed for each of the three major clinical service areas (Acute, Partnerships and Mental Health). These set out the current position together with the future changes and described proposals to change the clinical governance arrangements. The planned improvements had been discussed with senior managers and clinicians. It was proposed that the basic structure of a Board-wide approach to Acute, Mental Health and Partnership governance was retained, however, the reporting arrangements and remit would change to reflect the new organisational arrangements for both HSCPs and Acute Care. Both the Acute Clinical Governance Forum and the Mental Health Services (for which the NHS Board was directly accountable) would have a direct reporting line to the NHS Board's Clinical Governance Forum. Other services would report directly to the HSCP governance structures with an assurance/information line to the NHS Board's Clinical Governance Forum.

Dr Armstrong summarised the remit of the Acute, Mental Health and Partnership Governance Forums and explained that these would be adapted to reflect the changing accountabilities and organisational arrangements.

The role of the Clinical Governance Support Unit would be retained as a central function to ensure that there was a critical mass of skilled staff to support clinical

governance functions in the new organisational arrangements. This also ensured that there would be a consistent approach to implementing key clinical governance policies, ensuring the patient safety programmes were developed and implemented, and providing advice and support on clinical effectiveness guidance.

Dr Armstrong explained that the process of transition to the planned organisational arrangements was underway and acknowledged that ongoing development would occur but to mitigate transition risks, she described a number of key caveats. It was expected that HSCPs would submit proposed clinical governance arrangements for review to the Board Clinical Governance Forum. This forum would then advise the Board if they complied with current policy.

Rev Dr Shanks recognised the complexity in the arrangements, particularly between the NHS Board and the six Integrated Joint Boards (IJBs) and wondered how this would play out operationally. Mr Calderwood described the independence of IJBs but emphasised their interface with the NHS Board particularly in areas such as clinical quality and clinical standards. He recognised the tension between the strategic commissioning and the delivery agent role but cautioned that there had to be an assurance that IJBs were adhering to the strategic coordination of clinical governance as set by the NHS Board's Clinical Governance Forum.

Mr Sime considered that the success going forward would be in ensuring transparency especially at NHS Board level. NHS Board Members should be able to see and identify problems and seek assurances via reports from the Medical Director and Director of Nursing roles.

Mr Finnie asked about the NHS Board's role in directly managed services. Mr Calderwood explained that the Schemes of Delegation from the NHS Board to the HSCPs set out the key functions of the NHS Board's Clinical Governance Forum and its role in both directly NHS Board-managed services within Acute Care and selected regional Mental Health Services together with its role of quality assurance for each HSCP's directly managed services. He conceded that there would be a bedding down period over the summer but that the strategic commissioning lay with the IJB's Chief Officers and the HSCPs as sub-committees of the NHS Board. The NHS Board was the body corporate and, therefore, answerable to the Scottish Parliament, so it was paramount that NHS Board Members satisfied themselves in terms of monitoring and performance of the IJBs.

Ms Renfrew referred to the issues highlighted and explained that there would be an opportunity to look further at how this would all play out operationally at the May 2015 Quality and Performance Committee meeting where transition arrangements would be discussed further. **Director of Corporate Planning & Policy**

Dr Lyons welcomed this opportunity, particularly further discussion around the three diagrams illustrated in the NHS Board paper. Councillor O'Donnell also welcomed the opportunity to discuss this in more detail, particularly around Mental Health and Learning Disabilities and how contracts with the third sector would be managed at IJB level.

NOTED

22. STRATEGIC DIRECTON AND LOCAL DEVELOPMENT PLAN

A report of the Director of Corporate Planning and Policy [Board Paper No 15/15] asked the NHS Board to note the submission of the Strategic Direction and Local Delivery Plan to the Scottish Government in March 2015.

The Local Delivery Plan for 2015-16 was developed as an integral part of finalising NHSGGC's Strategic Direction for the coming year.

Ms Renfrew noted the risks and outstanding issues highlighted in the Local Delivery Plan which would be subject to further discussion with the Scottish Government. These related to:-

- Financial Issues – a number of risks within the Financial Plan still required to be finalised.

- Targets and Standards – given the financial and service pressures across the system, there would be significant challenges to deliver all of the required targets in 2015-16.

- Delayed Discharges – the plan required a major reduction in the current level of delayed discharges, including consistent delivery of the national targets to enable the Acute Sector to achieve the bed reductions included in the Savings Plan and improve unscheduled care.

- Service Change Proposals – the plan included a number of service change proposals which needed to be delivered during 2015-16 to achieve in-year balance and also proposals to be delivered from the start of 2016/17 to ensure that recurring balance was restored.

In considering finalising the Local Delivery Plan, Ms Renfrew explained that it was important to note that the Integrated Joint Boards (IJBs) would be in place from early in the new financial year with their new responsibilities for strategic planning of local services and substantial elements of unscheduled care. This had a range of implications for the Local Delivery Plan process.

The Scottish Government had provided initial feedback on the draft plan and discussion would continue over the next few weeks with a particular focus on the issues and risks outlined.

In response to a question from Councillor Rooney, Ms Renfrew confirmed that the financial elements would be included in a later version of the Local Delivery Plan – this version was a draft only that had been submitted to the Scottish Government. Councillor Rooney noted that non-recurring resources would be used to deliver the financial position for 2015-16 and worried about funding this gap in the future.

Mss Brown looked forward to seeing the revised draft in June which would be more specific around about the financial projections.

Councillor Rooney commented that the prescribing of the new hepatitis C drugs was a social justice issue and, as drugs were now available to cure this, NHS Boards had an obligation to provide this and, accordingly, ensure associated prescribing costs were included in the financial plan.

NOTED

23. MEETING THE REQUIREMENTS OF EQUALITIES LEGISLATION – A FAIRER NHSGGC – MONITORING 2013-15

A report of the Director of Corporate Planning and Policy [Board Paper No 15/16] asked the NHS Board to approve "A Fairer NHSGGC Monitoring Report 2013-15" and note the issues requiring further progress for 2015-16.

Ms Erdman explained that NHSGGC produced its third Equalities Scheme and Action Plan for 2013-16 to build on previous equalities work and the NHS Board was now two years into delivering these actions. She summarised the requirements on public sector organisations to comply with the Equality Act 2010, one of which was a requirement, by law, to publish this report on 27 April 2015.

Ms Erdman led the NHS Board through the monitoring report, which was constructed in two parts, with both an internal and external audience in mind. Firstly, it gave details of progress made in applying and understanding of discrimination into mainstream organisational activity such as planning, performance, leadership, listening to patients, service delivery, service redesign and increasing workforce knowledge and skills on equality issues. Secondly, it described progress against the equality outcomes where significant further work had been identified and was required to meet the three general duties.

She emphasised that the report showed the breadth of work on tackling inequality across all parts of NHSGGC and highlighted areas of good practice. It demonstrated the NHS Board's commitment to providing the highest quality services which were transparently fair and equitable for everyone.

Ms Micklem commended the huge amount of work ongoing and welcomed the halfway report on progress so far, given that there remained a list of further work required. She suggested future reports looked, in more detail, at data collection and the analysis of this so that continuous improvement was evident. In response to her further question, Ms Renfrew reported that the IJBs would be required to comply with the requirements in the Equality Act 2010 and further thought would be given as to how this would be undertaken locally as well as reported at NHS Board level.

Director of Corporate Planning & Policy

Ms Brown welcomed the detail in the report and linked it back to her comments made when discussing the Public Health Screening Programmes Annual Report 2013-14 where she alluded to the need for further equalities data information in relation to screening programmes uptake.

DECIDED

Director of Corporate Planning & Policy

- That, the "A Fairer NHSGGC Monitoring Report 2013-15" be approved.
- That, the issues requiring further progress for 2015-16, be noted.

24. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Officer, Acute Services [Board Paper No 15/17] asked the NHS Board to note progress against the national targets as at the end of February 2015.

Mr Archibald led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting

times - 18 Weeks Referral to Treatment (RTT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. He also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Councillor Macmillan sought more information around the Accident & Emergency waiting times, particularly at Glasgow Royal Infirmary and the Royal Alexandra Hospital. Mr Archibald reported that clinical and managerial staff had been working closely with Government colleagues to progress actions intended to reduce the length of time patients spent in NHSGGC's Emergency departments. These included regular on-site meetings of staff from all areas, "huddles", ensuring that discharge prescriptions were ready more quickly, ensuring discharge lounges were used to their full capacity and that discharge decisions were made as soon as possible. Furthermore, waiting times for the main Emergency Departments were now published weekly. Mr Archibald took the opportunity to refer to the hard work being undertaken by staff looking at "cause and effect" over the recent challenging few months. He paid tribute to their commitment in taking forward improvement actions to date.

Mr Calderwood described some proactive changes being made to address the challenging patient flow issues from Accident & Emergency departments. In NHSGGC, there was a significantly higher demand placed on Acute Services in terms of our population, than in other NHS Board areas. Going forward, it had been made clear that there would be no additional resources or funding. The priority, therefore, was to work within current resources and to ensure that the Local Delivery Plan was affordable in terms of providing unscheduled care in the future.

Dr Lyons referred to the delayed discharges information and noted the management actions being taken to address these, both at NHS Board and Local Authority level. Mr Archibald agreed that performance was disappointing and that IJBs would work to seek local solutions.

NOTED

25. FINANCIAL MONITORING REPORT FOR THE 11 MONTH PERIOD TO 28 FEBRUARY 2015

A report of the Director of Finance [Board Paper No 15/18] asked the NHS Board to note the financial performance for the 11 month period to 28 February 2015.

Mr White reported that the NHS Board was currently reporting a break-even outturn against budget for the 11 month period for 28 February 2015. At this stage, the NHS Board forecast that a year-end break-even outturn would be achieved.

He led the NHS Board through expenditure for the period as it related to Acute Services, Partnerships, Corporate Services and other budgets and capital.

He confirmed that, at this stage, the NHS Board was ahead of its year to-date cost savings target against plan.

NOTED

26. QUARTERLY REPORT ON COMPLAINTS: 1 OCTOBER – 31 DECEMBER 2014

A report of the Nurse Director [Board Paper No 15/19] asked the NHS Board to note the quarterly report on complaints in NHSGGC for the period 1 October to 31 December 2014.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints-handling performance of 78.5% of complaints responded to within 20 working days had been achieved.

Ms Crocket alluded to the issues attracting most complaints and highlighted that, across Partnerships and the Acute Services Division, these were clinical treatment, date for appointment, staff attitude/behaviour, and oral communication. She outlined some of the service improvements and actions being taken to address complaints both within the Acute Services Division and at Partnership level. She also noted the Scottish Public Services Ombudsman's reports and the recommendations contained therein which were submitted to the NHS Board's Quality and Performance Committee for monitoring purposes.

Ms Micklem referred to the online patient feedback system and noted that 118 received were praise for care. She asked how such praise was communicated back to the service and Ms Crocket reported that, on receipt, this was fed back immediately to the relevant staff.

In response to a question from Mrs McAuley regarding the consistent theme of staff attitude/behaviour in complaints, Ms Crocket agreed to provide more information in a future report, focusing on what local actions are being taken to address this. **Nurse Director**

NOTED

27. NHSGGC – ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS - STANDING ORDERS, COMMITTEE REMITS AND MEMBERSHIPS AND OTHER ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No 15/20] asked the NHS Board to approve, note and agree any revisions to the governance arrangements in place within NHS Greater Glasgow and Clyde.

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board to properly discharge its responsibilities and statutory functions.

DECIDED

1. That, the Standing Orders for the proceedings and business of the NHS Board and decisions reserved for the NHS Board be approved. **Head of Board Administration**

2. That, the Remits of the Standing Committees – Quality and Performance Committee, Audit Committee, Staff Governance Committee, Pharmacy Practices Committee and Area Clinical Forum be approved. **Head of Board Administration**

3. That, the memberships of the NHS Board's Standing Committees and the Non-Executive Membership of the Interim Committees and Integrated Joint Boards (once established) be approved. **Head of Board Administration**

4. That, the membership of the Adults with Incapacity Supervisory Body be approved. **Head of Board Administration**

5. That, the list of Authorised Officers to sign healthcare agreements and related contracts be approved. **Head of Board Administration**

28. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 20 JANUARY 2015

The minutes of the Quality and Performance Committee meeting held on 20 January 2015 [QPC(M)15/01] were noted.

NOTED

29. AREA CLINICAL FORUM MINUTES: 5 FEBRUARY 2015

The minutes of the Area Clinical Forum meeting held on 5 February 2015 [ACF(M)15/01] were noted.

NOTED

30. AUDIT COMMITTEE MINUTES: 24 FEBRUARY 2015

The minutes of the Audit Committee meeting held on 24 February 2015 [A(M)15/01] were noted.

NOTED

The meeting ended at 12:25pm.

NHSGG&C(M)15/04
Minutes: 31 - 58

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 23 June 2015 at 9:30a.m.

PRESENT

Mr A O Robertson OBE, DSc, LLB (in the Chair)

Dr J Armstrong
Mr J Brown CBE
Ms M Brown
Mr R Calderwood
Dr H Cameron
Ms R Crocket MBE (To Minute No 51)
Councillor M Cunning
Dr L de Caestecker
Councillor M Devlin
Professor A Dominiczak OBE
Mr R Finnie
Mr I Fraser (To Minute No 50)
Mr I Lee
Councillor M Macmillan (To Minute No 44)
Councillor J McIlwee
Ms R Micklem
Councillor M O'Donnell
Dr R Reid
Councillor M Rooney (To Minute No 51)
Rev Dr N Shanks
Mr D Sime
Mr M White
Mr K Winter

IN ATTENDANCE

Mr G Archibald	Chief Officer, Acute Services Division
Mr A Curran	Head of Capital Planning & Procurement (For Minute No 48)
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr D Loudon	Director of Facilities and Capital Planning (For Minute No 48)
Mrs A MacPherson	Director of Human Resources & Organisational Development
Ms P Mullen	Head of Performance (For Minute No 50)
Mr I Reid	Director of Human Resources
Ms G Woolman	Assistant Director, Audit Services, Audit Scotland (For Minute No 44)

ACTION BY

31. WELCOME AND APOLOGIES

Mr Robertson welcomed Ms G Woolman, Audit Scotland in attendance to present the Annual Report for the NHS Board and Auditor General for Scotland. He also introduced Ms A MacPherson, newly appointed Director of Human Resources and Organisational Development (to replace Mr I Reid who was retiring at the end of June).

Apologies for absence were intimated on behalf of Mrs S Brimelow OBE, Councillor A Lafferty, Dr D Lyons, Mr A Macleod and Mrs T McAuley OBE.

NOTED

32. DECLARATION(S) OF INTEREST(S)

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

NOTED

33. CHAIR'S REPORT

(i) Mr Robertson sought and received approval to discuss Item No 11 as NHSGGC Endowment Trustees. In doing so, he reported that, in order to consider Item No 11, the NHS Board meeting would be adjourned and Members reconvened as NHSGGC Endowment Trustees to approve the Endowment Fund Accounts to 31 March 2015. Thereafter, the NHS Board meeting would be reconvened to consider Item No 12 onwards.

(ii) Mr Robertson recorded that, during the last two months, he had completed all but one of the Non-Executive NHS Board Member annual appraisals. He thanked colleagues for their honesty and cooperation in this process and confirmed that a summary had been prepared for NHS Board development purposes.

(iii) On 29 April 2015, Mr Robertson, with members of the Executive Team, had a meeting with the Cabinet Secretary for Health, Wellbeing and Sport, Shona Robison MSP, where discussion included the migration to the new South Glasgow University Hospital, the NHS Board's resilience plans and its Local Delivery Plan (including recognition of the need for redesign and service change in accordance with the NHS Board's Clinical Services Strategy).

(iv) On 8 May 2015, Mr Robertson, accompanied by Dr J Armstrong, met up with Primary Care colleagues when visiting "hospital care in the community" services. In this regard, he referred to the Renfrewshire Pilot and ongoing work with the Community and Hospital services at the Royal Alexandra Hospital.

(v) On 11 May 2015, Mr Robertson, accompanied the Cabinet Secretary for Health, Wellbeing and Sport, on a walkround of the new South Glasgow University Hospital.

(vi) On 13 May 2015, Mr Robertson attended the turf-cutting at Bellahouston of the new Prince and Princess of Wales Hospice. That evening, he attended a celebratory event at the University of Glasgow Innovative Collaboration Awards where partnership working at the new South Glasgow University Hospital was recognised.

(vii) On 27 May 2015, Mr Robertson attended a thank you event for volunteers across the whole NHS Board's area to acknowledge their contribution and welcome their keenness to be involved in the new South Glasgow University Hospital campus. He acknowledged the value of their personal insight and engagement with staff and patients.

(viii) On 2 June 2015, Mr Robertson visited Westmarc to learn more about the design, build and fit of prosthetics. The service was located on the South Glasgow University Hospital campus and it looked forward to developing working relationships with orthopaedic surgeons there.

(ix) On 3 June 2015, Mr Robertson spent the day with the Cabinet Secretary for Health, Wellbeing and Sport when they visited the Centre of Integrative Care, the Beatson West of Scotland Cancer Centre and the South Glasgow University Hospital to meet a broad range of clinicians delivering unscheduled care to discuss ongoing collaborative working.

(x) On 8 June 2015, Mr Robertson met with Mr A Tough, the NHS Board's archivist, to discuss the possibility of hosting an exhibition of materials relating to the recent hospital closures and the associated moves to the new South Glasgow University Hospital.

NOTED

34. CHIEF EXECUTIVE'S UPDATE

(i) On 15 May 2015, Mr Calderwood hosted a visit from representatives from Powys Teaching Health Board in Wales to discuss, in detail, progress made in NHSGGC in relation to health and social care integration.

(ii) On 5 June 2015, Mr Calderwood accompanied the First Minister to visit the new Children's Hospital on the new South Glasgow University Hospital campus.

(iii) On 15 June 2015, Dr Margaret Macguire, currently Nurse Director at NHS Tayside, was appointed as the new Nurse Director (to replace Ms R Crocket). She would join the NHS Board in September.

(iv) On 16 June 2015, Mr Calderwood held the first of a series of development team sessions with the new Senior Management Team.

(v) Mr Calderwood congratulated the Chairman who was awarded an Honorary Doctorate of Science from the University of Glasgow on 17 June 2015.

Councillor Rooney asked whether any national decision had been made yet in relation to the future of the Golden Jubilee National Hospital. Mr Calderwood confirmed that, at the request of the SGHD, NHSGGC formally submitted an option appraisal looking, in particular, at opportunities for an A&E service in the North West of Glasgow to complement the NHS Board's Clinical Services Strategy. Since then, the Cabinet Secretary had replied to confirm that the Golden Jubilee National Hospital should continue to provide services as a national centre of excellence. Given that, the priority for NHSGGC was to complete its current Clinical Services Strategy.

NOTED

35. MINUTES

On the motion of Dr R Reid, seconded by Rev Dr N Shanks, the minutes of the NHS Board meeting held on Tuesday, 21 April 2015 [NHSGGC(M)15/03] were approved as an accurate record and signed by the Chair.

NOTED

36. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted.

NOTED

37. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE

A report of the NHS Board's Medical Director [Board Paper No 15/21] asked the NHS Board to note an update on the progress made by the Acute Services Division in implementing the SPSP Deteriorating Patient workstream.

Dr Armstrong explained that improving care for the deteriorating patient (a patient who was acutely unwell and at risk of further worsening of their condition) had been identified as one of the nine priority areas for improvement within the Scottish Adult Acute Safety Programme. It was a continuation of preceding work within the SPSP General Ward workstream which focused on reliable implementation of the Early Warning Score to support physiological monitoring of patients but now extended significantly the areas for development.

She outlined the aim of the workstream and the three primary drivers to meet that aim, explaining that it was an extensive set of expectations, therefore, there had been an agreed initial focus on the testing of Scottish structured response processes. The expectation was for each clinical team to implement reliable Early Warning Scoring assessment and a structured response.

Dr Armstrong summarised the outcome measures and process measures associated with the workstream and explained that its implementation was supported through the Clinical Governance Support Unit and, in particular, a Clinical Improvement Lead to augment medical engagement, improvement coaching and cross-system leadership. A pilot ward in the Royal Alexandra Hospital had made good progress in establishing the structured response and Dr Armstrong reported that the measure was an all-or-nothing measure so all elements needed to be demonstrated to have occurred before the clinical practice was counted as having met the requirements.

Dr Armstrong summarised two other related projects that supported this workstream and described an accelerated spread plan that had been agreed for the Royal Alexandra Hospital where the plan was that all teams would be actively involved in the workstream by the end of 2015.

Dr Armstrong led the NHS Board through some development issues that had to be progressed including the need to identify local clinical needs to complement the role of the Clinical Improvement Lead.

Ms Brown welcomed the involvement of a team at the Beatson Oncology Centre who were now at the engagement/start-up phase. She wondered if there was a specific plan/pathway to meet the needs of patients who were receiving care outwith their specialist wards to spot any decline in that patient group? Dr Armstrong reported that this matter was on the radar of the workstream and would be discussed further to ensure a systematic review of such patients and explained that that was one of the reasons the entire hospital of the Royal Alexandra was chosen as the pilot so that a whole-hospital approach could be taken.

On that point, Mr Sime asked if statistics were recorded on such a patient group? Mr Archibald reported in the affirmative, however, explained that the priority was to

always seek to align patients with appropriate specialties and to ensure any boarding of patients was kept to a minimum.

In reviewing the primary drivers of the workstream, Ms Micklem recognised some were areas for improvement but regarded others as areas that should be taken for granted – she wondered if there was a distinction to be made regarding targets and current expectations? Dr Armstrong described the proactive approach taken when a patient did deteriorate to improve clinical care.

NOTED

38. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/22] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level and led the NHS Board through a summary of performance in relation to:-

- Staphylococcus aureus bacteraemias (SABs)
- Clodistrium Difficile (C.Diff)
- Surgical Site Infection (SSI) rates for caesarean section, knee anthroplasty, repair of neck of femur procedures and hip anthroplasty procedures
- The Cleanliness Champions Programme
- Healthcare Environment Inspectorate (HEI) inspections

Ms Crocket referred to the two unannounced inspections by the HEI at Glasgow Royal Infirmary (on 24 and 25 February 2015) and Inverclyde Royal Infirmary (on 24 and 25 March 2015) – both inspections resulted in no requirements and no recommendations made. In this regard, she outlined the work that had been done across the whole of NHSGGC to achieve this and thanked local staff, in particular, for their continuing endeavours which achieved this excellent outcome.

Councillor Rooney commended work going on throughout NHSGGC to meet these continuing challenging targets. Ms Micklem agreed and recognised the continued proactive work being undertaken by all staff to meet these targets. In response to her question concerning the MRSA Screening Project where NHSGGC's performance was currently 80%, Dr Armstrong explained that work was ongoing to achieve 90% compliance with the clinical risk assessment and that compliance was increasing.

NOTED

39. UPDATE ON SMOKEFREE POLICY CAMPAIGN

A report of the Director of Public Health [Board Paper No 15/23] asked the NHS Board to note the update on the Smokefree Policy Campaign and to support the implementation of its three recommendations.

Dr de Caestecker provided an update on NHSGGC's Smokefree Campaign, its impact to date as well as identifying future developments.

Dr de Caestecker highlighted that, despite the initial success of the NHS Health Scotland national campaign in March 2015, the level of smoking across all hospital sites in NHSGGC remained a concern. Although the number of informal complaints had fallen, the number of formal complaints about smoking remained at a similar level to that before the campaign and there was a significant issue with high number of patients, visitors, staff and contractors smoking at the main entrance of the new South Glasgow University Hospital. A monitoring exercise was being undertaken which would establish a baseline to measure the effectiveness of new interventions and as a comparison to previous NHS Acute sites. Staff had been identified to undertake a smoking warden role at the South Glasgow University Hospital and training for the identified staff was due to be delivered before the end of June 2015. Dr de Caestecker extended this training opportunity to all NHS Board Members particularly as, given that the campaign encouraged all staff to adopt a role around enforcing the policy, feedback indicated that many staff felt uncomfortable challenging smokers with concerns about potential abuse and lack of appropriate skills.

Mr Finnie supported the Scottish Government's current proposed legislation to support enforcement of Smokefree grounds on NHS hospital sites. Dr de Caestecker agreed and outlined the content of its initial consultation on these proposals, confirming that NHSGGC similarly supported the proposals but sought further detail around how it would be implemented.

In response to a question from Councillor Cunning regarding support given to inpatients on their admission to hospital, Dr de Caestecker summarised service provision and confirmed that patients were indeed offered nicotine replacement treatments on admission and, thereafter, patients were followed up on hospital discharge.

Dr de Caestecker agreed with Ms Brown's point around support given to mental health patients and explained that an implementation plan had been developed and a Project Board established to explore further the issues with this client group, in particular, inpatients who were unable to leave hospital grounds.

In response to a question from Councillor Rooney, Dr de Caestecker confirmed that the NHS Board's policy did include e-cigarettes.

DECIDED

- That the update on Smokefree Policy Campaign be noted.
- That implementation of the following three recommendations be supported:-
  - Training for managers and staff to enable them to enforce the Smokefree Policy across all sites; **Director of Public Health**
  - Create capacity to enable the role of Smoking Wardens to be delivered at the new South University Glasgow Hospital; **Director of Public Health**
  - Maintain and enhance the current campaign activity across all sites with a focus around the new South Glasgow University Hospital. **Director of Public Health**

40. KEEP WELL AND CHRONIC DISEASE MANAGEMENT PROGRAMME UPDATE

A report of the Director of Public Health [Board Paper No 15/24] asked the NHS Board to note the Keep Well and Chronic Disease Management Programme update and, in particular, the disinvestment planning and programme legacy developments as well as the Chronic Disease Management developments and House of Care Early Adopter Programme.

Dr de Caestecker led the NHS Board through an update as follows:-

- **NHSGGC Keep Well Programme disinvestment planning and programme legacy** – Dr de Caestecker provided a summary of the updated funding position from 2013 to 2017 illustrating, in particular, the significant programme budget reductions. Although not due to take effect until April 2015, NHSGGC made the decision to discontinue the delivery of Keep Well health checks from 1 April 2014. As a consequence, four programme elements were withdrawn or reorientated during 2014/15. Following consultation with Partnership Directors and Health Improvement Managers, it was agreed to manage the 2015/16 and 2016/17 budget allocation at a programme level rather than applying respective percentage funding reduction across all Partnerships. Budget allocations were prioritised to minimise risks to existing contractual commitments. The three year disinvestment period provided some time for Partnerships to identify other funding sources for service and/or staff by April 2017, however, the discontinuation of funding from April 2017, coupled with wider financial pressures, would make that very challenging.

- **Update on key developments within NHSGGC Primary Care Chronic Disease Management (CDM) and associated House of Care Early Adopter Programme** – Dr de Caestecker explained that Chronic Disease Management (CDM) was a generic term for systematic delivery of coordinated healthcare for populations with established long-term conditions. NHSGGC invested substantially in an extensive, well established CDM programme which delivered practice-based CDM care for patients with five major chronic diseases. The programme was delivered in Primary Care but strongly underpinned by a whole-population perspective across all aspects of service planning, coordinated by a multi-disciplinary planning group. The current programme aimed to provide person-centred care for patients with any combination of the five major chronic disease co-morbidities. The "House of Care" model represented a tangible and proven improvement framework that allowed services to embrace care planning to support the self management of people living with long-term conditions. This approach had been endorsed by the Scottish Government to address the needs of people living with multiple long-term conditions and was aligned with the Scottish Government's route map of deliverables to achieving its 2020 Vision through developing new models of Primary Care.

  NHSGGC, along with NHS Lothian and NHS Tayside, was participating in a two year Early Adopter Programme Initiative in partnership with the Scottish Government, Health & Social Care Alliance and British Heart Foundation to apply the model in Scotland during 2015 to 2017. Nine GP practices across Glasgow City and East Dunbartonshire had volunteered to apply the House of Care approach within their existing CDM programme/service. The programme would initially target a population of patients with existing diagnoses of type 2 diabetes and/or coronary heart disease from disease registers and work

collaboratively to define clearly a workable range of care pathway models for these patients which would have common and variable components to fit with practice systems.

Dr de Caestecker explained that, despite the discontinuation in Keep Well funding, learning from the programme, amassed over the seven years, had been successfully translated into transferable and practical improvement actions for the Primary and Secondary prevention of long-term conditions. It was vital that NHSGGC continued to commit to strengthening system-wide integrated prevention activities across health, social care and third sector partners to maximise leverage of the NHS Board's existing investments in health improvement.

Rev Dr Shanks recorded his deep concern about the Scottish Government's withdrawal of the funding of the Keep Well Programme but was encouraged to see NHSGGC had made the best out of this. Dr Reid agreed and highlighted the work of the South Asian Anticipatory Care Programme in undertaking work with this patient group and addressing any misconceptions.

In response to a question from Councillor Rooney, Dr de Caestecker reported that the SGHD did not undertake an Equalities Impact Assessment (EQIA) prior to the withdrawal of funding. She added that the staff involved with the delivery of the Keep Well Programme had all found alternative employment or were in fixed term posts whereby their contracts had come to an end.

Ms Brown welcomed the approach being taken to continue the Keep Well legacy, recognising that the programme had amassed a great deal of learning.

NOTED

UNDER STANDING ORDER 12, THE NHS BOARD ACCEPTED A MOTION TO ADJOURN ITS MEETING TO ALLOW IT TO RECONVENE AS NHSGG&C's ENDOWMENT TRUSTEES FOR THE FOLLOWING ITEM:-

41. STATEMENT OF ACCOUNTS FOR 2013/14

A report of the Director of Finance asked the Trustees to adopt the Statement of Accounts for the financial year ended 31 March 2015 and authorise the Director of Finance to sign the Statement of Trustees Responsibilities and balance sheet.

Mr White presented an audited set of accounts for Trustees' approval following scrutiny at the NHS Board's Audit Committee meeting on 16 June 2015. He explained that the Endowments Funds accounts required to be adopted prior to the NHSGGC Consolidated Annual Accounts being approved by the NHS Board.

Mr White took the Trustees through the accounts, the Statement of Trustees Responsibilities and the Independent Auditors Report to the Trustees.

Mr White thanked his finance teams for their work throughout the year and, in particular, for their endeavours in consolidating the Endowments Funds with the NHSGGC Financial Statements for the first time this year.

DECIDED

- That, the Statement of Accounts for the financial year ended 31 March 2015 be adopted.

- That, the Director of Finance sign the Statement of Trustees Responsibilities and Balance Sheet be authorised. **Director of Finance**

UNDER STANDING ORDER 12, THE NHS BOARD MEETING WAS RECONVENED TO COMPLETE THE BUSINESS TO BE TRANSACTED.

42. GOVERNANCE STATEMENT 2014/15

A report of the Convenor of the Audit Committee [Board Paper No 15/26], comprising a Statement of Assurance by the Audit Committee and a Governance Statement which was part of the Annual Accounts for 2014/15, was submitted. Subject to approval of this report, the NHS Board was asked to authorise the Chief Executive to sign the Governance Statement as the Accountable Officer.

The Convenor of the Audit Committee, Mr R Finnie, presented the report.

The Audit Committee, at its meeting on 16 June 2015, received a report which provided members with evidence to allow the Committee to review the NHS Board's system of internal control for 2014/15. Based on the review of internal control, the Audit Committee recommended for approval both the Statement of Assurance to the NHS Board on the system of internal control within NHS Greater Glasgow and Clyde and the Governance Statement for NHS Greater Glasgow and Clyde.

Mr Finnie took the NHS Board through Appendix 1 – Statement of Assurance by the Audit Committee and Appendix 2 – Governance Statement. He reported that there were no significant matters relating to the system of internal control which required to be disclosed in the Governance Statement and that the Audit Committee recommended that the NHS Board approve the Governance Statement and that this be signed by the Chief Executive as Accountable Officer.

DECIDED

1. That the Statement of Assurance from the Audit Committee be accepted and noted. **Director of Finance**

2. That the Governance Statement be approved for signature by the Chief Executive. **Chief Executive**

43. STATEMENT OF ACCOUNTS FOR 2014/15

A report of the Director of Finance [Board Paper No 15/27] asked the NHS Board to approve for submission to the Scottish Government Health Directorate (SGHD), the Statement of Accounts for the Financial Year Ended 31 March 2015.

Mr White introduced the accounts which had previously been considered in draft form by the Audit Committee. He advised that the Revenue Resource Limit, Capital Resource Limit and Cash Limit had been achieved.

The accounts were prepared, as required, to comply with the requirements of International Financial Reporting Standards (IFRS) and in a format required by the SGHD, so that these could be consolidated with the accounts of other NHS Board to form the accounts of NHS Scotland.

The Audit Committee had scrutinised the Director of Finance's report at its meeting on 16 June 2015 as well as the final draft set of accounts. As a consequence, the Audit Committee could confirm to the NHS Board meeting that it recommended that the NHS Board adopt the accounts for the year to 31 March 2015.

Mr White advised that, at its meeting on 16 June 2015, the Audit Committee received confirmation from Audit Scotland of its intention to issue an unqualified opinion in respect of the financial statements, the regularity of financial transactions undertaken by the NHS Board, and on other prescribed matters.

Mr White confirmed that the NHS Board's Financial Statements disclosed that the NHS Board had met its financial targets. He took members through the key elements of the accounts including the Operating Cost Statement, Balance Sheet and Cash Flow Statement to the year ended 31 March 2015. Mr White summarised the main issues arising from his report and confirmed that Audit Scotland's opinion was that the financial statements gave a true and fair view of the accounts.

DECIDED

1. That the Statement of Accounts for the financial year ended 31 March 2015 be adopted and approved for submission to the Scottish Government Health Directorate. **Director of Finance**

2. That the Chief Executive be authorised to sign the Director of Finance's report, the remuneration report, the Statement of the Chief Executive's responsibilities as the Accountable Officer of the NHS Board and the Governance Statement. **Chief Executive**

3. That the Chair and the Director of Finance be authorised to sign the Statement of NHS Board Members Responsibilities in respect of the Accounts. **Chair and Director of Finance**

4. That the Chief Executive and the Director of Finance be authorised to sign the Balance Sheet. **Chief Executive and Director of Finance**

44. AUDIT SCOTLAND'S ANNUAL REPORT ON THE 2014-15 AUDIT

A report of the Director of Finance [Board Paper No 15/28] asked the NHS Board to note the report by the external auditors, Audit Scotland, on the 2014/15 Audit of NHSGGC. The report had already been reviewed by the Director of Finance and scrutinised by the Audit Committee.

Ms Woolman summarised the key findings to emerge from Audit Scotland's 2014/15 audit. During the course of the year, Audit Scotland assessed the strategic and financial risks which NHSGGC faced, they audited the financial statements and reviewed the use of resources and aspects of performance management and governance. Ms Woolman set out Audit Scotland's key findings as they were presented to the Audit Committee at its meeting held on 16 June 2015 and summarised these as follows:-

- The financial statements;
- The Board's financial position;
- Governance and accountability;
- Best value, use of resources, and performance.

Ms Woolman confirmed that the report showed the issues identified by Audit Scotland as having been considered by management and agreed actions to address them.

In response to a question from Councillor O'Donnell concerning the future audit arrangements for the newly formed Health and Social Care Partnerships, Mr White confirmed that, across the NHS Board's six Health and Social Care Partnerships, there would be varying dates of when they went "live" – within a range of September 2015 to April 2016.

NOTED

45. PROPOSED CAPITAL PLAN 2015-16 TO 2017-18

A report of the Director of Finance [Board Paper No 15/29] asked the NHS Board to approve the proposed allocation of funds for 2015/16, note the current indicative allocations for 2016/17 and 2017/18, and delegate to the Capital Planning Group, the authority to allocate any additional available funds against the 2015/16 Capital Plan throughout the year.

Mr White advised that the current forecast total capital resources available to the NHS Board in 2015/16 amounted to £88.584m. He set out how the NHS Board planned to deploy this initial allocation of capital funds in individual schemes in 2015/16. Allocations for 2016/17 and 2017/18 were only indicative sums at the present time. The figures illustrated in Appendix 1 of the NHS Board paper for future years were chiefly provided for information purposes to assist Members in understanding the likely scale of ongoing capital commitments beyond 2015/16. He confirmed a balanced capital position for 2015/16 with planned gross expenditure of £88.584m being matched by an equivalent level of funding.

Mr White led the NHS Board through the proposed Capital Plan, incorporating proposed capital schemes across Acute Services, Board and Partnerships including Mental and Oral Health. Expenditure on all capital schemes would be monitored throughout the year and reported to the Capital Planning Group to ensure that a balanced capital position was maintained for 2015/16.

Councillor Rooney asked where proposed capital projects such as that for Clydebank Health Centre were included. Mr Calderwood explained that written confirmation was awaited from the SGHD regarding Clydebank and Greenock Health Centres and their funding as part of the Scottish Government's investment in the Non-Profit Distributing (NPD) programme.

Ms Micklem asked about the risk management processes regarding slippage. Mr Calderwood referred to the monthly monitoring system and the robust accountability processes surrounding the Capital Programme. He also alluded to issues often outwith the NHS Board's control which may, throughout a financial year, result in slippage, such as, planning delays and site conditions.

In response to a question from Mr Lee regarding the £2.35m allocation for HI&T schemes in 2015/16, Mr White explained that this related to expenditure to fully equip the nSGH, with additional amounts in 2016/17.

In response to a question from Councillor McIlwee regarding Inverclyde Royal Hospital, Mr Calderwood confirmed that work commenced this year to look at the framework of the building, its infrastructure and service provision.

DECIDED

1. That the proposed allocation of funds for 2015/16 be approved. **Director of Finance**

2. That the current indicative allocations for 2016/17 and 2017/18 be noted.

3. That the Capital Planning Group be delegated the authority to allocate any additional available funds against the 2015/16 Capital Plan throughout the year. **Director of Finance**

46. 2015/16 FINANCIAL PLAN

A report of the Director of Finance [Board Paper No 15/30] was submitted, providing an overview to the NHS Board of the major elements within the Financial Plan, highlighting key assumptions and risks and explaining how it was proposed to address the cost savings challenge which the NHS Board faced to achieve a balanced financial outturn in 2015/16.

Mr White provided an overview of the process used to develop the plan; an explanation of the funding uplift that the Board would receive in 2015/16; the most recent projection of the scale of the financial challenge which the NHS Board would need to address if it was to succeed in managing its revenue resource limit for 2015/16 and the cost savings plan for 2015/16 which would enable the NHS Board to address that financial challenge and deliver a break even financial outturn for the year.

Mr White took the NHS Board through the most salient points of the Financial Plan. The SGHD had confirmed a headline funding uplift for 2015/16 of £34.7m or 1.8%. The current expected cash releasing service target was expected to be £40.9m.

Mr White referred to the proposals for funding following discussions with Directors which had led to pressures and possible investments being captured and agreed. The 2015/16 Financial Plan assumed that the pressures and investments would be funded but Mr White cautioned that it might be prudent to increase the challenge in order to address additional pressures that may emerge and an update on this would be provided to the NHS Board during the year as appropriate. **Director of Finance**

In response to a question from Mr Sime regarding any impact the Financial Plan was going to have on frontline services, Mr Calderwood reported that much of this detail had already been considered at the NHS Board Member Away Sessions as part of the approval process for the Local Delivery Plan, relevant operational management governance meetings within the Acute Services Division and at Partnerships. It had also been shared with the SGHD, emphasising the need to look more radically and consistently across NHSGGC in terms of the challenges that needed to be met. Rev Dr Shanks added that more detail would have been helpful, particularly in relation to the risk management approach to meeting these challenges and in the NHS Board making associated choices. Ms Brown agreed and thought it would be useful to see more context and the percentage of distribution of cost savings per operational area to understand better the impact on local services and to identify any area required to meet a disproportionate saving over others.

Mr Finnie also wondered about the financial risks associated with the establishment of Integrated Joint Boards (IJBs) especially if they all became legal bodies (as referred to earlier) at varying times between now and April 2016. Mr Calderwood explained that the NHS Board had submitted its draft Financial Plan to the SGHD in February 2015 as required, as part of its Local Delivery Plan submission. The NHS Board then submitted an update to the draft plan to the SGHD in March 2015, again as part of the Local Delivery Plan submission. This process was the NHS Board's best endeavour to reach a balanced budget and he recognised that in so doing, there were operational challenges. He added that these would continue to be monitored monthly.

Councillor Rooney asked about the £1.5m provision for incremental progression for consultants. Mr Calderwood explained that this referred to the process of discretionary points for consultant medical staff.

DECIDED

Director of Finance

- That the Financial Plan for 2015/16 be approved.

47. 2014/15 ANNUAL REVIEW

A report of the Head of Performance [Board Paper No 15/31] asked the NHS Board to note the details of the 2014/15 Annual Review.

Ms Mullen confirmed that this year's Annual Review was scheduled to take place on Thursday 20 August 2015. It would be a Ministerial Annual Review and its main purpose was for the NHS Board to be held to account for its performance during 2014/15. The focus would be on the impact the NHS Board was making in delivering outcomes as set out in the Local Delivery Plan.

She led the NHS Board through an outline of the day which would be chaired by Shona Robison MSP, Cabinet Secretary for Health, Wellbeing and Sport.

NOTED

48. PROPERTY ASSET MANAGMENT STRATEGY (PAMS)

A report of the Director of Facilities & Capital Planning [Board Paper No 15/32] asked the NHS Board to note the Annual Property and Asset Management (PAMS) submission as returned to the SGHD for its analysis on the health of the built environment pan Scotland.

Mr Loudon explained that all NHS Boards had property and asset management strategies for land, buildings and other assets including equipment, vehicles and IT which sought to optimise the utilisation of assets in terms of service benefit and financial return. The PAMS (covering years 2015-2019) was submitted to the SGHD in June 2015 and provided an update on the progress made in the last 12 months.

Mr Loudon explained that the current and future property portfolio for NHSGGC would be driven and shaped by the needs and demands of clinical services. With this in mind, he noted that 2015/16 would see the commencement of one of the most dynamic periods in the history of NHSGGC's estate, during which time the NHS Board's property portfolio would be in an unprecedented transitional phase, chiefly as

a result of the commissioning and opening of the facilities at the South Glasgow University Hospital and the resultant closures of three major acute hospitals.

NOTED

49. TRANSFER AND COMMISSIONING OF THE NEW SOUTH GLASGOW UNIVERSITY HOSPITAL AND ROYAL HOSPITAL FOR SICK CHILDREN

A report of the Chief Officer, Acute Services [Board Paper No 15/19] asked the NHS Board to note a summary of the transfer to and commissioning of the new South Glasgow University Hospital and the Royal Hospital for Sick Children.

Mr Archibald provided an overview of the significant activity associated with the Adult and Children's Hospitals migration programme which started on Friday 1 May 2015 and concluded on Monday 14 June 2015. He set out the timetable for the migration programme, the infrastructure established to ensure that it was delivered safely, the sites and cohorts of services and patients moving during that period, workforce information, a summary of operational issues that arose during the migration programme, and unscheduled care performance.

The NHS Board's unscheduled care performance in the very early days of operating from the South Glasgow University Hospital had been a key challenge and the NHS Board was being supported by colleagues from the Scottish Government to assist and support local staff in maximising the benefits of the model in place. Scheduled care performance had been maintained throughout the period of significant change.

Mr Archibald concluded that the migration of services to both the Adult and Children's Hospitals had now been completed and the South Glasgow University Hospitals campus was now fully operational. The immediate focus was the improvement of unscheduled care while continuing to maintain the performance of scheduled care services.

He thanked all staff and partner organisations (principally, the Scottish Ambulance Service) for their contribution to the success of the migration programme since it was first discussed in detail in mid-2014 to its conclusion, particularly as the scale and complexity of the moves had not been attempted before in the NHS in Scotland, and the entire programme was delivered safely with no adverse clinical incidents or harm coming to any patient who was moved during the seven week period.

NOTED

50. NHSGGC'S INTEGRATED PERFORMANCE REPORT (INCLUDING WAITING TIMES AND ACCESS TARGETS)

A report of the Head of Performance [Board Paper No 15/34] asked the NHS Board to note the content and format of the NHS Board's Integrated Performance Report, particularly as this was the first iteration of such an integrated report and work was in progress to further refine its content.

Ms Mullen explained that this report brought together high-level system-wide performance information (including all of the waiting times and access targets previously reported to the NHS Board) with the aim of providing the NHS Board with a clear overview of the organisation's performance in the context of the 2015/16

Strategic Direction – Local Delivery Plan. An exceptions report would accompany all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and indicating a timeline for when to expect improvement.

Ms Mullen explained that the report was work in progress and would welcome input from Members to inform its further development. The indicators highlighted in italics were those indicators that each of the Health and Social Care Partnerships had a direct influence in delivering. Each of those indicators could be disaggregated by each of the Health and Social Care Partnership areas. For those indicators that could be disaggregated, the Chief Officer of the Partnership experiencing a persistent adverse variance of 5% or more would report direct to the NHS Board. This reflected the fact that the first line of scrutiny and oversight of performance improvement would be undertaken by the Integrated Joint Boards (IJBs).

Ms Mullen explained that the report drew on a basic balanced scorecard approach and used the five strategic priorities outlined in the 2015/16 Strategic Direction – Local Delivery Plan. Some indicators fitted under more than one strategic priority but were placed in the priority considered the best fit. The most up-to-date available data had been used which meant that it was not the same for each indicator. The time period of the data was provided and performance compared against the same period in the previous year. From that, a direction of travel was calculated.

In summarising overall performance, of the 24 indicators that had been assigned a performance status based on their variance from target/trajectory, five were red (outwith 5% of meeting trajectory) and eight were amber (within 5% of meeting trajectory).

The NHS Board considered the format to be excellent, with a comprehensive level of detail. Rev Dr Shanks in particular, welcomed the NHS Board's performance in tackling delayed discharges and ongoing work with Partnership Chief Officers and the Director of Planning & Policy's continued work to identify and address any issues causing delays, looking at revised scrutiny and escalation arrangements. The overall aim was to achieve immediate and continuing reductions in the number of delays given the pressures on hospital beds.

Ms Micklem wondered whether it would be useful to produce exception reports for those measures rated as amber and showing a downward trend when compared to the same period the previous year and Ms Mullen agreed to consider this for future reports. **Head of Performance**

NOTED

51. QUARTERLY REPORTS ON COMPLAINTS AND FEEDBACK 1 JANUARY TO 31 MARCH 2015

A report of the Nurse Director [Board Paper No 15/35] asked the NHS Board to note the Quarterly Report on Complaints and Feedback in NHSGGC for the period 1 January to 31 March 2015.

Ms Crocket led the NHS Board through the detail presented on complaints received and completed in the quarter, confirming that an overall complaints handling performance of 82% of complaints responded to within 20 working days had been achieved.

She referred to the Patient, Carer And Public Feedback Report, noting that this was the first report of its kind, and invited the NHS Board to reflect on its content and advise of any refinements required. This report looked at feedback, comments and concerns received centrally and in local services, and identified areas of service improvement and ongoing developments. Future reports would continue to be presented alongside the corresponding Quarterly Complaints Reports.

NOTED

52. NHSGGC – ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS - UPDATE

A report of the Head of Board Administration [Board Paper No 15/36] asked the NHS Board to approve the remit and membership of the Acute Services Committee, the membership of the Area Clinical Forum and note the Officers authorised to sign on behalf of Scottish Ministers in relation to signing matters relating to the acquisition, management and disposal of land.

In response to a question from Mr Finnie regarding the objective of the Acute Services Committee, Mr Hamilton agreed to revise the wording. **Head of Board Administration**

In relation to the Authorised Signatories, it was suggested that the Director of Facilities and Capital Planning be added. **Head of Board Administration**

DECIDED

Head of Board Administration

- That the remit and membership of the Acute Services Committee be approved.
- That the membership of the Area Clinical Forum be noted.
- That the Officers authorised to sign, on behalf of Scottish Ministers in relation to signing matters relating to the acquisition, management and disposal of land be noted.

53. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 20 JANUARY 2015

The minutes of the Quality and Performance Committee meeting held on 19 May 2015 [QPC(M)15/03] were noted.

NOTED

54. AREA CLINICAL FORUM MINUTES: 2 APRIL 2015

The minutes of the Area Clinical Forum meeting held on 2 April 2015 [ACF(M)15/02] were noted.

NOTED

55. PHARMACY PRACTICES COMMITTEE: 12 MAY 2015

The minutes of the Pharmacy Practices Committee meeting held on 12 May 2015 [PPC(M)15/01] were noted.

NOTED

56. AUDIT COMMITTEE MINUTES: 2 JUNE 2015

The minutes of the Audit Committee meeting held on 2 June 2015 [A(M)15/02] were noted.

NOTED

57. BOARD CLINICAL GOVERNANCE FORUM MINUTES: 20 APRIL 2015

The minutes of the Board Clinical Governance Forum meeting held on 20 April 2015 [Board Paper No 15/37] were noted.

NOTED

58. ANY OTHER BUSINESS

Mr Robertson reported that this would be the last NHS Board meeting attended by the current Director of Human Resources, Ian Reid. Mr Reid was retiring at the end of June after 33 years service to the NHS, firstly in Argyll & Clyde Health Board and latterly within NHSGGC. Mr Robertson thanked Mr Reid for his insight and commitment to the HR function and the NHS Board and wished him well in his retirement. Mr Reid thanked Mr Robertson for his kind words and had been honoured to work with Executive and Non-Executive colleagues at NHSGGC, particularly through recent times which had seen many changes.

NOTED

The meeting ended at 12:50pm.

NHS Greater Glasgow and Clyde

Board Meeting
Tuesday, 23 June 2015 **Board Paper No. 15/33**

CHIEF OFFICER, ACUTE SERVICES

TRANSFER AND COMMISSIONING OF THE NEW SOUTH GLASGOW UNIVERSITY HOSPITAL AND ROYAL HOSPITAL FOR SICK CHILDREN

Recommendations:

The NHS Board is asked to note:-

- this report summarising the transfer to and commissioning of the new South Glasgow University Hospital and the Royal Hospital for Sick Children

Introduction

This report provides an overview of the significant activity associated with the Adult and Children's Hospitals migration programme, which started on Friday 1 May 2015 and was concluded on Monday 14 June 2015.

The report sets out the timetable for the migration programme, the infrastructure established to ensure that the programme was delivered safely, the sites and cohorts of services and patients demitted during that period, workforce information, a summary of operational issues that arose during the migration programme and unscheduled care performance.

Timetable

The migration of services from the Western Infirmary (WIG), Victoria Infirmary (VIG), Mansionhouse Unit, Gartnavel General Hospital and the Royal Hospital for Sick Children was the largest hospital migration programme ever undertaken in the United Kingdom. It was an immensely complex and difficult programme to construct and deliver.

The Migration Programme was first discussed in detail in mid 2014 and the plans developed with clinical teams, partner organisations, principally the Scottish Ambulance Service, and colleagues in other NHS Boards also supported the moves, especially the Royal Hospital for Sick Children in Edinburgh.

The scale and complexity of the moves had not been attempted before in the NHS in Scotland and this entire programme was delivered safely, with no adverse clinical incidents, or harm coming to any of the patients who were moved during the 7 week period.

The order of the moves was determined thus (and a note of the actual numbers of patients moved)

Week 1	SGH - Critical Care / A&E / Medical & Surgical In-Patients	181 patients
Week 2	ENT / WIG Critical Care (CCU) / Vascular and Renal services	91 patients
Week 3	Victoria Infirmary CCU / A&E / In-Patient wards	86 patients
Week 4	Victoria Infirmary In-Patients	77 patients
Week 5	Western Infirmary (ICU & HDU) / RHSC - NICU cots	
	Western Infirmary A&E / In-Patients / Brownlee Unit	130 patients

Week 6	RHSC (NICU) / Gartnavel General Hospital In-Patients / WoSCC 2 wards	53 patients
Week 7	RHSC A&E closed / In-Patient wards / remaining PICU patients / Out Patient department closed and relocated	61 patients

Almost 700 patients were transferred, safely, from demitting sites into their new units / wards over this intensive seven week period.

Migration infrastructure

Daily Huddles

Meetings involving key Directors (and nominated deputies) were established throughout the period of the moves and took place at 12noon each day (Monday - Friday); these were chaired by the Chief Officer. Each meeting was guided by an agenda and the action notes circulated immediately after the meeting.

The meeting was structured to discuss -

- A recap of the previous weekend moves;
- Notes of the previous meeting;
- An overview of the next series of moves;
- Update reports on the building, equipment and IT, staffing, service delivery (clinical and non clinical), current UCC performance by site, and agreed actions.

The meetings were first held on Tuesday 5 May and last on Thursday 11 June.

Command Centre

A Command Centre was established during the entire migration period and provided control of all administrative, communication and move activities on both demitting sites and the new Hospital(s), leading up to, during and immediately following the moves each weekend.

The Command Centre was led by a designated Director to direct the physical transfer process and maintain continuity of service provision during the transfer period.

Service Transfer Owners were identified for each discrete move many months in advance, and these were split into Sending and Receiving Teams for the duration of the physical moves.

The Command Centre was established on the 4th Floor of the new Adult Hospital and was equipped to undertake live monitoring of the moves and maintain contact with key staff during the moves.

The core Command Centre Team comprised of the Commander (Director), a Move Lead (a senior member of the new Hospitals Project Team), Facilities Manager, BMG (the external company), and the Scottish Ambulance Service, others were co-opted as required.

Workforce Migration

The establishment of new South Glasgow Adult and Children's Hospitals presented a significant logistical challenge to the Board, resulting in over 10,000 staff being brought together on a single Hospital site.

As part of these moves over 6,000 staff required to change their work location, and a further 1,700 staff moved within the site. Detailed workforce and migration plans were developed over a number of years with services to take the migration process forward.

Staff side Engagement/Governance

On the Move Workforce Change Project was overseen by the Workforce Executive Group, which was chaired by the Chief Executive and the Workforce Director, supported by the Employee Director, other Board Directors and the Chief Officer Acute and Chair of the Acute Partnership Forum.

This group sponsored specific workstreams to support the project. In particular, for staff, the Workforce Advisory Group and Human Resources Sub Group dealt specifically with staff related elements and were supported by multiple trade union and HR colleagues. This included guidance for managers and staff on the change programme, introducing a transition service, considering opportunities for young people as part of community gain and considering the change management requirements of services. There was also local planning in each speciality that was led by professional leads along with partnership colleagues and these groups focused on the overall service redesign to ensure that patient flow was optimised through the new service. The overall Workforce Change Plan was agreed fully in partnership with trade unions colleagues.

Communication

Through the Communication Sub-Group, a wide variety of bespoke communication methods were deployed to keep staff informed of the change. This included individual emails to staff, team and core briefs, updates in Staff News and regularly updated positions on the On The Move StaffNet pages.

In addition the staff guide to the Hospitals and the Leadership toolkit were also publicised and available on the StaffNet pages. Staff roadshows were held across all affected sites and travel clinics were organised to ensure staff had as much information as possible regarding travel and transport to the site. Over 9,000 staff attended an orientation session to the new hospitals and the office block, this included a DVD presentation and walk around of their new work environment.

Support for Migration

Additional bank nursing support was agreed to support the orientation of staff into the new Hospitals. The bank staff were utilised to support wards, receiver and sender teams during the weekends of the moves as well as ward support in the week following the migration. In total almost 4,000 band 5 hours and over 5,000 band 2 hours were used, and the fill rate for these shifts was 94% across the entire programme. Over 200 Facilities staff were also employed on a temporary basis to support the migration process. There were, equally, other support teams including Imaging, Pharmacy and HI&T who provided additional support to services.

Transition

There have been 206 staff who have not been able to relocate with their service during the changes. From this 199 staff have been successfully redeployed into alternative posts throughout NHS Greater Glasgow & Clyde. The remaining 7 staff are all in interim posts until such times as substantive posts can be secured for them. They are all in a robust and well established process however, and are being communicated with regularly with regards to vacancies and opportunities. It is anticipated that these remaining staff will be allocated posts shortly. The average turnaround from someone being displaced to be deployed into a changed role has been 28 days, which is much better than in previous change programmes.

Leaver Analysis

Leavers have been monitored since August 2014 to assess if increased numbers of staff have been leaving the Board as they did not wish to relocate to the new hospital. To date there have been 30 staff who have left as they did not wish to transfer however, this equates to 2% of overall leavers within the Board in this time period.

Operational issues

In a very complex building, welcoming an increasing number of staff, patients and visitors each weekend, some initial difficulties were inevitable, however the local staff, and their managers have worked tirelessly to resolve these as they arose.

Other operational issues which have emerged, such as early capacity issues at the Canteen, ongoing difficulties with the Pneumatic Tube System, and how lifts are used.

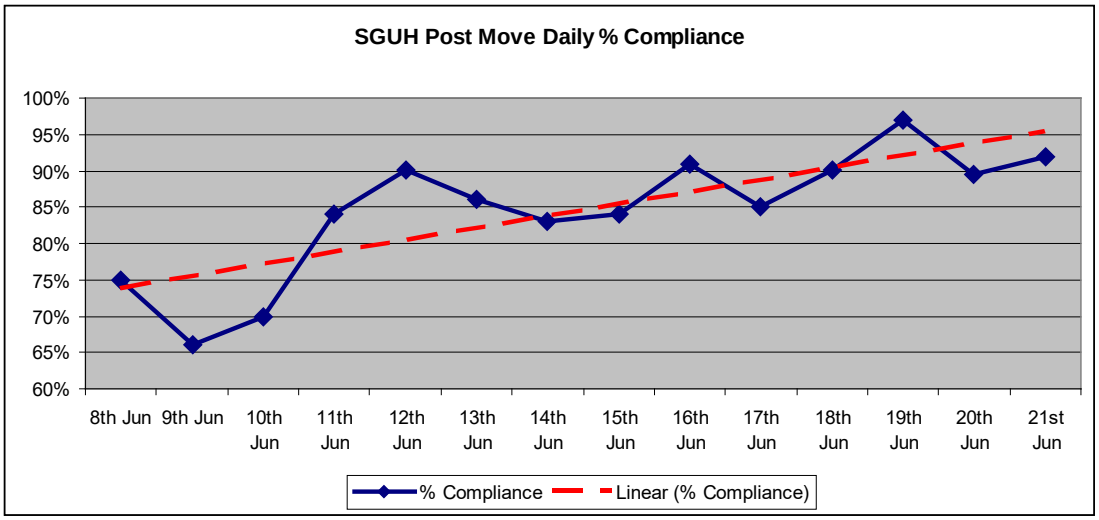
As these issues emerged, these were quickly identified, isolated and fixed. The Daily Hospital Huddles identified where these issues were causing day to day difficulties and, if necessary, these were escalated the same day to the Management Team Huddle to be highlighted and addressed.

Unscheduled Care Performance

Our Unscheduled Care performance in the very early days of operating out of the South Glasgow University Hospital has been a key challenge, and we are being supported by colleagues from the Scottish Government to assist and support local staff in maximising the benefits of the model we have in place.

Emergency Attendance

Daily ED Compliance profile for the hospital post final moves on 8th June is detailed below. On the 8th and 9th June the ED attendance was reported as 292 and 272 respectively, the predicted annualised average daily attendance is 270. The daily average ED attendance rate for the reported period has been 235 patients.

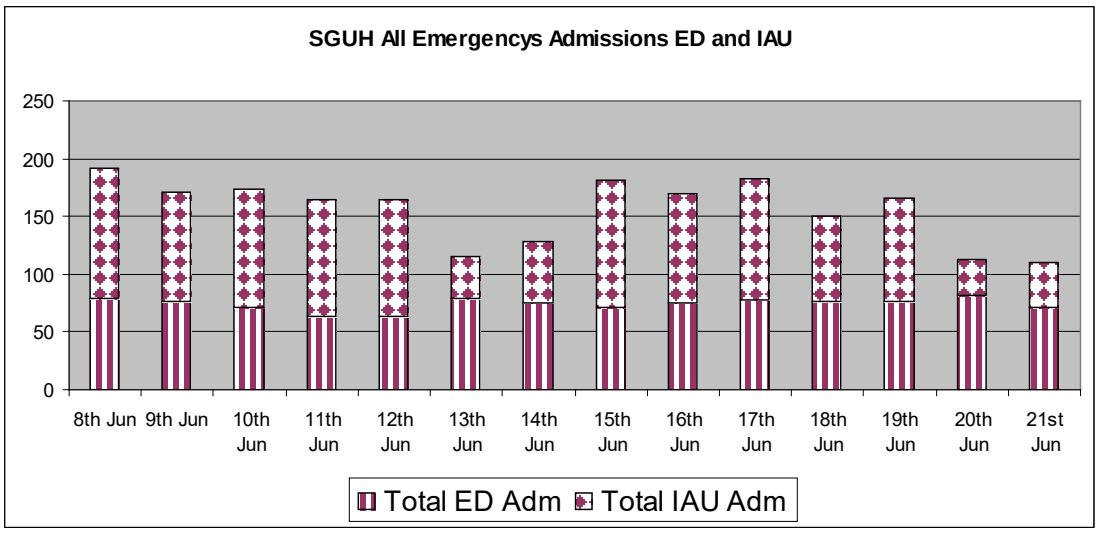


In respect of the 4 hour UCC guarantee, average weekly performance has been

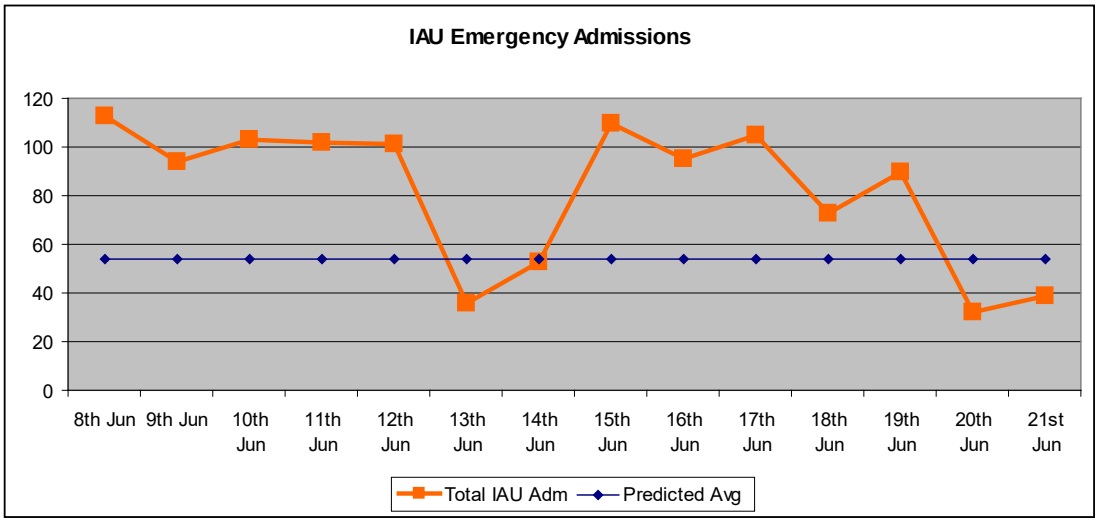
- from 8th June to 14th June 2015 = 78.6%;
- since Monday 15th June 2015 = 89.6%; and
- the range from 8th June 2015 to 21st June 2015 has been from 66% to 97%.

Emergency Admissions

The Admissions for ED and IAU GP Referred Emergency patients since 8th June is reported at an average of 156 patients per day. This breaks down to a daily average of 82 GP Referred Attendances through IAU and 74 patients admitted from ED.



The IAU average of 85 patients per day is 57% greater than the predicted average of 54 patients per day.



Early challenges have emerged in the Immediate Assessment Unit (IAU). The IAU is a dedicated facility for patients referred to hospital by their GP, who do not need to come through the A&E Department and instead are received in a dedicated unit for rapid assessment by senior clinicians. From here patients have rapid access to diagnostic tests and decisions about whether or not they require admission, or can be discharged, are taken quickly by senior specialists.

IAUs are designed to stream patients who have already had an initial assessment of their condition undertaken by their GP so they can avoid any potential further delay in their care by going to A&E unnecessarily. They are 24/7 units staffed with dedicated specialist consultants. Our A&E unit receives patients who are brought to hospital by emergency ambulance or patients who self present.

Unscheduled care performance in the Royal Hospital for Sick Children, pre and post migration has been maintained. Since week ending 24 May 2015, weekly performance against the 4 hour target has been 100%, 99%, 100%, and 97%, and in the latest week available (week ending 21 June 2015) was 99%.

Scheduled Care Performance

Our scheduled care performance has been maintained throughout this period of significant change.

Although not all of the data for May (and June) is available to analyse at a level that we would use to report on, our early assessment of real time performance of the services transferred suggests that

- our excellent TTG performance has been maintained throughout the migration programme (in all of our Hospitals, and including Paediatrics);
- the Board is maintaining its performance in relation to out patients seen within the 12 week waiting time guarantee;
- patients are being seen within the national target time of 4 weeks for all Diagnostics tests; and
- Delayed Discharges (under 14 days) were reduced in the April census to the lowest number achieved this year.

Clinical highlights

Renal Services carried out 10 kidney transplants in the first three weeks of the renal service transferring into the new hospital. The renal service has benefited from the move by increasing the overall number of beds from 63, up to 65.

In Haemato-Oncology Services, 2 patients received Bone Marrow Transplants (BMT) within the first week of the service transferring into the new hospital. The enhanced diagnostic and laboratory support on site significantly assist with timely clinical decision making for this patient cohort. The move to the new hospital has also enabled the service to increase the number of BMT beds from 19 up to 24.

Concluding Remarks

The migration of services to both the Adult and Children's Hospital(s) has now been completed, and the South Glasgow University Hospitals campus is now fully operational. The immediate focus is the improvement of unscheduled care, while continuing to maintain the performance of scheduled care services.

Grant R Archibald
Chief Officer
Acute Services
NHS Greater Glasgow & Clyde

22 June 2015

NHSGG&C(M)18/05
Minutes: 103 - 129

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the William Quarriers Conference Centre, 20 St Kenneth Drive, Glasgow, G51 4QD
on Tuesday 16th October 2018

PRESENT

Mr J Brown CBE (in the Chair)

Mrs J Grant
Dr J Armstrong
Cllr C Bamforth
Mr M White
Ms D McErlean
Mr S Carr
Cllr J Clocherty
Ms M Brown
Ms J Donnelly
Ms J Forbes
Mrs A Thompson
Mr R Finnie
Dr D Lyons
Mr J Matthews OBE
Cllr S Mechan
Dr M McGuire
Mr A MacLeod
Ms A. Monaghan
Dr L de Caestecker
Mr A Cowan
Mr I Ritchie

IN ATTENDANCE

Mr T Steele	Director of Estates and Facilities
Mr J Best	Interim Chief Operating Officer
Mr G Forrester	Deputy Head of Administration
Mr G Archibald	Chief Operating Officer
Mrs A MacPherson	Director of HR and OD
Mr Alan Harrison	Lead Pharmacist Community Care
Mr D Leese	Chief Officer, Renfrewshire HSCP (To item 114)
Mr A McLaws	Director of Corporate Communications
Ms S Manion	Chief Officer, East Dunbartonshire HSCP
Ms B Culshaw	Chief Officer, West Dunbartonshire HSCP
Ms J Murray	Chief Officer, East Renfrewshire HSCP (To item 112)
Mr D Williams	Chief Officer, Glasgow City HSCP (To item 112)
Ms H Watson	Head of Service, Planning, HI & Commissioning, Inverclyde HSCP (To item 112)
Ms M Speirs	Hub Accountant (To item 112)
Mr D Harley	Planning & Performance Manager (To item 112)
Mrs G Mathew	Secretariat Manager

ACTION BY

103. APOLOGIES

Apologies for absence were intimated on behalf of Prof Dame Anna Dominiczak DBE, Ms Susan Brimelow OBE, Mr Ian Ritchie, Ms Rona Sweeney, Cllr Mhairi Hunter, Cllr Jonathon McColl, Ms Elaine Vanhegan and Ms Louise Long.

Ms Helen Watson was in attendance on behalf of Ms Louise Long.

NOTED

104. DECLARATIONS OF INTEREST

Mr Brown invited Board members to declare any interests in any of the agenda items being discussed.

No declarations of interest were made.

NOTED

105. MINUTES

On the motion of Mrs Thompson, seconded by Ms Forbes, the minutes from the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 21st August 2018 [Paper No. NHSGG&C (M) 18/04] were approved and accepted as an accurate record.

NOTED

106. MATTERS ARISING FROM THE MINUTES

a) ROLLING ACTION LIST

The Rolling Action List [Paper No. 18/45] was considered.

Mr Cowan noted inconsistencies with regard to the ongoing and closed actions. Following discussion, the Board agreed that any items which were included on future agenda's or on the forward planner but that the action had not yet been completed, would remain open on the Rolling Action List until such times as the action itself had been completed, for the purposes of clarity. **Secretary**

On that basis, the Board agreed the closure of items on the Rolling Action List which had been completed and agreed that those items still to take place would remain on the List as ongoing. **Secretary**

Dr de Caestecker clarified that item 58 of the Rolling Action List – Public Health Priorities, was ongoing and Dr de Caestecker had recently discussed with Chief Officers and had attended a number of meetings including Community Planning Partnerships and Integrated Joint Boards, to provide an overview of the Public Health Strategy and obtain feedback from those groups. This item remained ongoing, with feedback to be provided to the Public Health Committee in due course. **Dr de Caestecker**

NOTED

107. CHAIR'S REPORT

Mr Brown reported that he had met with the Cabinet Secretary, Ms Jeane Freeman OBE at the recent Chair's meeting, where there was discussion about Scottish Government priorities, including; governance, waiting times, cancer waiting times, pace of integration and mental health services.

Mr Brown went on to note that the Scottish Government had approved the Blueprint for Good Governance, a copy of which would be circulated to members. A Steering Group was being established. Further detail and discussion on this would take place at the Board Development session on 8th and 9th November 2018.

The work of the Global Citizenship Programme continued and Mr Brown was pleased to welcome Ms Anisa Omar, Policy Manager for the Programme, who attended the meeting to observe. Mr Brown noted that the Minister for International Development would be in attendance at the next Programme Board meeting.

Mr Brown attended a meeting of the Black Minority Ethnic (BME) Employee Forum and was pleased to note the establishment of this Forum along with the Disability Forum and the virtual Lesbian Gay Bisexual Transgender Intersex (LGBTI) Forum.

Mr Brown highlighted a number of visits he had undertaken recently to a number of charities including a visit to the Beatson West of Scotland Cancer Care Centre for the Target Ovarian Cancer 10th Anniversary, a visit to the Maggie's Centre at Gartnavel General Hospital, the opening of the MacMillan Information and Bereavement Centre, and a visit to the Teenage Cancer Trust. Mr Brown noted the considerable amount of work undertaken by all of the charities.

Mr Brown advised he had also attended the Precision Medicine Summit on 10th September along with Mrs Grant, which focused on research, innovation, science and technology to improve the delivery of medicine.

NOTED

108. CHIEF EXECUTIVE'S REPORT

Mrs Grant advised that work continued in relation to National and Regional Planning in respect of Trauma, Planned Care and Cancer. In addition, she highlighted the roll out of the maternity and neonatal care Best Start Programme. Mrs Grant recently met with Chief Officers to discuss local priorities across the system.

Mrs Grant attended a meeting of the eESS Programme Board and implementation of the eESS system would be completed by the end of November 2018.

Mrs Grant and Mr Brown also met with the Cabinet Secretary and visited the Imaging Centre of Excellence Building based at Queen Elizabeth University Hospital.

Mrs Grant highlighted the development programme being undertaken by the Senior Management Team and noted a recent session facilitated by Mr Michael West focusing on compassionate leadership.

Mrs Grant introduced Mr Tom Steele to Board members. Mr Steele took up the position of Director of Estates and Facilities on the 1st October 2018. The appointment of Mr Jonathan Best to the position of Programme Director for the Moving Forward Together Programme was noted, as was the appointment of Mrs Gail Caldwell as the Director of Pharmacy. Mr Alan Hunter would shortly return from secondment and has been appointed to undertake the role of Director of Access.

Mrs Grant attended a recent meeting with colleagues from Glasgow City Council in relation to the potential industrial action, and invited Mr Williams to provide an update on the current situation.

Mr Williams advised the Board that as of 1st October 2018, care services previously provided by Cordia were transferred to the Health and Social Care Partnership. Following legal proceedings under equality legislation, a process to address the Court findings and make appropriate backdated payments to affected staff was commenced however Trade Unions did not feel this was progressing quickly enough. Unison and GMB Trade Unions subsequently balloted members and members voted to take industrial action. The planned action would take place on 23rd and 24th October and would involve approximately 8,000 staff members from various services including catering, cleaning and care services. Agreement has been reached with the Trade Unions to ensure that essential life and limb cover was maintained for the most dependant and vulnerable service users. Despite plans to ensure minimal disruption to services, Mr Williams noted a likely impact on the wider health system including Acute Services, Scottish Ambulance Service and Primary Care Services. Delays may be experienced in Acute Service referrals and an increase in delayed discharges is expected. A National Contingency Planning Meeting will take place on Monday 22nd October and Mr Williams continued to work closely with Mr Archibald to minimise the impact on the wider system. The situation has prompted accelerated discussions regarding winter planning and the redirection of patient flows.

Mr Brown thanked Mrs Grant, Mr Williams and Mr Archibald for assurance to the Board regarding the ongoing discussions and efforts to reduce the impact of the industrial action.

NOTED

109. PATIENTS STORY

Dr McGuire, Director of Nursing, introduced a short film which featured a patient's recent experience of a significant stay at Queen Elizabeth University Hospital and the impact of life changing surgery.

Following the feedback received from the patient, Dr McGuire assured the Board of the commitment to implementing the lessons learned about communication and staff had found the comments received very helpful.

Mr Brown wished to note thanks on behalf of the Board to the patient for providing useful feedback.

NOTED

110. DELIVERING FOR TODAY, INVESTING FOR TOMORROW – THE GOVERNMENTS PROGRAMME FOR SCOTLAND 2018/19

The Board considered the paper "Delivering for Today, Investing for Tomorrow – The Government's Programme for Scotland 2018/19" [Paper No. 18/46] presented by the Chief Executive, Mrs Jane Grant. Mrs Grant provided an overview of the context of the document. The paper was an annual publication which sets out the Scottish Government's priorities for the year ahead, building on previous commitments and detailed the approach to tackling key challenges.

Mrs Grant noted the key themes included within the paper; improving support for good mental health; getting the right care in the right place at the right time; Acute and Secondary Care; social care and support; improving our population health; using research, innovation, digital and data capabilities to improve health; working across public services for better health; our NHS workforce and getting the best start in life.

Mr Brown thanked Mrs Grant for the update and invited questions from Board members.

In response to questions from Board members regarding specific reference to dementia within the document, Mrs Grant assured the Board that dementia would be managed under the wider mental health umbrella and there remained a commitment to address this as a priority area.

NOTED

111. PUBLIC HEALTH COMMITTEE – UPDATE

Mr Matthews, Chair of the Public Health Committee, noted that there had not been a meeting of the Committee since the Board Meeting in August. Mr Matthews indicated that work continued to promote and implement the themes and principles of the Public Health Strategy, as agreed at the last Board Meeting. Dr de Caestecker had attended a number of meetings with Community Planning Partnership Boards and Integration Joint Boards to discuss local plans and obtain feedback on the Strategy. Dr de Caestecker would continue this and would feedback the outcome of discussions to the next Public Health Committee Meeting. Mr Matthews went on to note other significant areas of work for the Committee including the focus on blood borne viruses and the Children's Neighbourhoods Programme. In addition, the Committee continued to seek opportunities to apply research and learning outcomes.

Director of Public Health

Mr Brown thanked Mr Matthews for the update and thanked the work of the Committee in promoting public health priorities.

NOTED

112. GREENOCK, CLYDEBANK AND NORTH EAST MENTAL HEALTH – FULL BUSINESS CASES

The Board considered the Full Business Cases [Paper No. 18/47] for the Greenock, Clydebank and North East Mental Health Hub developments, presented by the Director of Estates and Facilities, Mr Tom Steele.

Mr Steele noted the three Full Business Cases detail the Hub developments for each

of the projects; however the summary paper provided an overview of all three projects. The Board were asked to approve the Full Business Cases for all three schemes for submission to the Scottish Government Capital Investment Group on 13th November 2018; approve the bundling strategy as outlined in the Summary and Bundling paper; note that each of the schemes had been assessed as value for money, affordable and achievable; approve the underwriting of design fees to allow continued progress whilst the approval process was underway; approve the proposal to enter into a DBFM contract in respect of the bundle upon approval by the Scottish Government of the Full Business Cases and approve the matters detailed in Appendix 1.

Mr Steele noted that Appendix 1 contained highly technical information. Mr Steele also noted that some elements of the FBC were commercially sensitive, and as such, had been redacted in places. Mr Steele would be happy to discuss any further information including the redacted information, should Board members require this.

Board members were comfortable that the language contained within Appendix 1 was standard DBFM contract language.

Mr Brown thanked all of those who had contributed to the development of this work and invited questions from Board members.

In response to questions from Board members regarding inpatient provision for mental health, Mr Harley explained the North East Mental Health facility would be designed in a flexible way to accommodate a range of patient needs.

In response to questions from Board members regarding the potential risks of the delays associated with the Clydebank facility, Ms Culshaw noted that work was currently underway to ensure sufficient access needs. Although this was a complex site, the overall risks had been reduced significantly.

The Board were satisfied that there was adequate management of the risks associated with the Clydebank project, given that extensive access works had commenced, and were satisfied with the management of the risks associated with the underwriting of design fees.

In response to questions from Board members regarding the learning obtained from incidents at Queen Elizabeth University Hospital and the Royal Hospital for Children, Ms Culshaw noted that the Capital Management Team were involved with all of the Hub projects, as well as the QEUH and RHC, therefore learning was being fed in continuously as the project progressed.

In response to questions from Board members in relation to the financial close for Clydebank, Ms Speirs clarified that a further document which detailed the financial close for Clydebank would be brought to a future Board meeting, circa June 2019. **Director of Estates and Facilities**

The Board agreed all of the recommendations numbered 1 to 6 set out within Paper 18/47.

Mr Brown thanked everyone involved on behalf of the Board.

APPROVED

113. MOVING FORWARD TOGETHER

The Board considered the paper 'Moving Forward Together Implementation Phase Update' [Paper No. 18/48] presented by the Medical Director, Dr Jennifer Armstrong. Dr Armstrong detailed the progress against the 5 main actions which included presentation of the blue prints to each of the 6 IJB's; development and agreement of the implementation phase programme process; appointment of a Programme Director and Programme Support; appointment of the key members of the Corporate Management Team and Senior Clinical leadership to the Programme Workstreams; and development of the communications and engagement framework.

Mr Best noted that the Moving Forward Together Executive Group met on 12th October and described the establishment of both the Stakeholder Reference Group and Workforce Reference Group. The workstream leadership appointments were approved by the Corporate Management Team. The fundamental purpose of Moving Forward Together Programme remained accessible services, closer to home.

Dr Armstrong went on to describe the regional plans to establish the QEUH as one of the national major trauma units and development of a rehabilitation model. Further information on this would be presented to the Board as this developed. Dr Armstrong also noted the development of a West of Scotland Systemic Anti Cancer Therapy Strategy and a further update would be provided to the Board in December on both these regional developments. **Medical Director**

Mr Brown thanked both Dr Armstrong and Mr Best for a positive update. Mr Brown remarked that emphasis on accessible services closer to home was clear. Questions were invited from Board members.

In response to questions from Board members regarding the term "a range of emergency local hospitals" Dr Armstrong clarified that this referred to the current local hospitals.

In response to questions from Board members regarding the availability of fully detailed proposals, Dr Armstrong clarified that priority was being given to progress areas that could be implemented rapidly, there would be a financial framework developed and presented to the Board in due course. Implementation of immediate changes would continue. Mr White indicated that financial planning was considering the short, medium and long term requirements. **Medical Director**

Mr Brown noted that the Finance and Planning Committee had discussed the engagement process and Mr McLaws indicated that a considered approach was being given to the engagement process, due to the complexity of the overall vision. It was agreed that a paper which detailed the plan for engagement would be useful to provide reassurance. **Director of Communications**

Mr Carr raised concerns regarding the absence of detail about the financial investment required to fulfil the aims of the programme. Mrs Grant understood Mr Carr's concerns and explained that due to the complexities of the project and

emerging priorities, it was not possible to provide full and complete financial investment information at this stage. Mrs Grant agreed, however, that some information of the estimated financial implication would be useful.

Mr Brown thanked those involved on behalf of the Board and noted that Board members would welcome participation in early discussions at key stages as the programme developed.

NOTED

114. PRIMARY CARE IMPROVEMENT PLANS 2018/19

The Board considered the paper 'Primary Care Improvement Plans 2018/19' [Paper No.18/49 presented by the Chief Officer Renfrewshire HSCP, Mr David Leese. The paper provided an update on the implementation of the new General Medical Services Contract, including the development of Primary Care Improvement Plans in each HSCP. Mr Leese noted the main areas covered within the report.

Mr Brown thanked Mr Leese for the report and invited questions from the Board members.

In response to questions from Board members in relation to workforce capability and planning, and the potential risk of destabilising other parts of the wider system, Mr Leese described a number of areas being progressed including advanced nurse practitioners, link workers, and work to collect data on staff numbers within GP practice. A principle has been adopted to ensure that any recruitment would only be progressed if it did not have an adverse effect on other parts of the system.

In response to questions from Board members in relation to quality improvement, clusters and peer reviews, Mr Leese indicated that in all areas practices continued to work in clusters and explore innovative ways in which they can work together.

Mr Brown thanked Mr Leese for the update and the work to date. The Board requested that 6 monthly progress reports be presented and Mr Leese would prepare the next report for the February 2019 Board meeting.

Chief Officer, Renfrewshire HSCP

NOTED

115. WINTER PLAN 2018/19

The Board considered the paper 'Winter Plan 2018/19' [Paper No. 18/50] presented by the Medical Director, Dr Jennifer Armstrong. Dr Armstrong described the cross system approach undertaken in the development of the Plan. The Board were asked to approve the draft Winter Plan and acknowledge the possibility of 115 to 150 additional beds and other resources, recognising that this may cost up to £8m; acknowledge that further work would be undertaken prior to final submission to the Scottish Government and approve that delegated authority be given to the Chief Executive to approve the final plan and ensure appropriate sign off by 30th October.

In response to questions from Board members regarding the financial impact, Mr White indicated that approximately £8m had been made available last year to support additional winter need. For this year, £2.1m had been made available and Mr White

expected that a further £2m would be identified from within the Financial Plan, which would reduce the overall financial risk to approximately £4m. Discussions were ongoing with the Scottish Government regarding additional winter funding to meet the proposed range of actions.

Mrs Grant went on to note that Chief Officers had been working with Acute colleagues to address cross system challenges, including delayed discharge, to develop robust contingency plans. Mr Williams noted that Glasgow City IJB had recently carried out an evaluation of commissioned intermediate care beds and Mr Williams would present this to a future Acute Services Committee.

Chief Officer, Glasgow City HSCP

Board members suggested an amendment to the description of the development of 72 hour supported community care. Board members felt that the use of the phrase "breathing space" may be confused with the national mental health organisation of the same name.

Mr Brown thanked Dr Armstrong and was pleased to note the cross system development of winter plans and the use of an innovative approach.

In summary, the Board identified and noted the risks associated with winter planning. Board members were content to approve the draft plan and the recommendations contained within the report, and endorsed the potential requirement of between 115 and 150 additional beds. The Board also acknowledged the financial position, and pending discussions with Scottish Government, and delegated authority to the Chief Executive to spend up to £8m should the funding be available.

APPROVED

116. ACUTE SERVICES COMMITTEE - UPDATE

The Board considered the minutes of the Acute Services Committee Meeting [Paper No. ASC (M) 18/05] of 18th September 2018. Mr Finnie provided an overview of the key areas discussed at the meeting including in depth scrutiny of the performance report and the finance report. Mr Finnie assured the Board that the Committee review in detail, the unmet measurable areas, fully discussed each, and sought assurance of the actions in place to address these.

Mr Brown thanked Mr Finnie for the update and invited questions and comments from Board members.

In response to questions from Board members regarding an update on the water issue at RHC, Mrs Grant noted that this would be covered under the HAIRT report.

Ms Brown raised concern regarding the governance of minutes of Board Committees being brought to the Board without first being ratified by their respective Committee. Mr Brown noted that minutes that have not yet been ratified by their Committee, were marked with a classification to denote that they were in draft and had been approved by the Chair of the committee. Ms Brown accepted this, however, would prefer that only ratified minutes were made available to the Board. Mr Brown noted the time delay this would create in terms of flow of minutes to the Board, however, asked that Mr Forrester consider ways in which final, Committee ratified minutes, could be republished for completeness.

Deputy Head of Corporate Governance and Board Administration

NOTED

117. NHSGGC INTEGRATED PERFORMANCE REPORT

The Board considered the paper 'NHSGGC Integrated Performance Report' [Paper No. 18/51] presented by the Director of Finance, Mr Mark White. The paper detailed high level performance information with the aim of providing Board members with a clear overview of the organisation performance in the context of the 2018-19 Corporate Objectives.

Mr White noted areas meeting or exceeding target including access to a range of services such as Drug and Alcohol Treatment, Alcohol Brief Interventions, Psychological Therapies and IVF Treatment, which all continued to either meet or exceed the target. Other areas meeting or exceeding the target include the cancer 31 day waiting time trajectory which continued to be met for the fourth consecutive month; the number of C-Difficile cases remained positive against target; and the overall response rate to Freedom of Information requests continued to exceed target. Overall financial performance remained within trajectory and current performance represented a significant improvement on the same position reported in the previous year. Mr White noted that monthly compliance with the 18 week Referral to Treatment target remained fairly positive with the August 2018 position of 88.5% against the target of 90.0%.

Mr Brown thanked Mr White for the update and Mr Archibald was invited to provide further detail on Acute performance.

Mr Archibald thanked Mr White for the overview of the report and thanked Mr Finnie and the Acute Services Committee for comments. Mr Archibald noted that work continued to identify the key factors and actions to address these. Mr Archibald praised the efforts of staff to meet the Cancer 31 day waiting time trajectory, however noted that the 62 day target remained an area for improvement at 76.9%. Urology remained an area of concern, as did recruitment to posts, which continued to pose challenges nationally. Mr Archibald advised the Board of a number of actions being undertaken to address issues with implementation of a 7 day waiting time for suspected head and neck cancers and the introduction of an escalation point for all cancers.

Mr Brown thanked Mr Archibald for the update and invited comments and questions from Board members.

Mr Matthews wished to note his gratitude to the dedicated staff at the Beatson West of Scotland Cancer Centre for welcoming him at his visit there last week. The work of the team at the Beatson Centre was commendable and truly inspiring. Mr Brown thanked Mr Matthews for his comments and noted how valuable Board members visits were in terms of engagement with staff.

Mr Archibald went on to describe the performance of the percentage of new outpatients waiting more than 12 weeks for a new outpatient appointment. As at August 2018, the percentage was 71.6%, which indicated a decline from June 2018 performance. A range of actions were being undertaken to address this including the reduction of demand by redirection to more appropriate services; virtual clinics and

the introduction of the "attend anywhere" pilot.

Following discussion and questions from Board members regarding the understanding of the causes of increased demand, Mr Carr requested that a paper be drafted for consideration by the Acute Services Committee.

Director of Finance

Following discussion and questions from Board members regarding the changing morbidity of the population, Dr de Caestecker agreed to provide a presentation to the Board Seminar on analysis of the data.

In response to questions from Board members regarding the performance of Child and Adolescent Mental Health Services, Mrs Manion provided an overview of the work being undertaken both locally and nationally to improve performance. Mr Brown noted the ambitious challenge to return to a 90% performance rate by December 2018. Mrs Manion agreed that the task was indeed ambitious, however remained fairly confident of its achievement. The Board requested a further update on this at the February 2019 Board meeting.

Chief Operating Officer

Director of Public Health

Dr McGuire provided an update on the number of delayed discharge patients across NHSGGC. As at August 2018, there were a total of 184 patients delayed which represented a deterioration in performance from the previous month. Mrs Manion noted the actions being undertaken by HSCP colleagues to reduce the number of delays experienced by patients including partnership working with care homes and the development of models of intermediate care. The emergent issues have been discussed in the context of the winter plan.

Chief Officer, East Dunbartonshire HSCP

Mr Brown thanked all those involved in production of the performance report and for the update.

NOTED

118. HEALTHCARE ASSOCIATED INFECTION REPORT

The Board considered the paper 'Healthcare Associated Infection Report' [Paper No. 18/51] presented by the Medical Director, Dr Jennifer Armstrong. The report described the validated HPS/ISD data for Quarter 2 from April to June 2018. Dr Armstrong reported a total of 105 validated cases of *Staphylococcus aureus Bacteraemia* (SAB) which was above the national rate. This remained a priority and in addition to the regular GGC SAB Group meetings, Infection control doctors/microbiologists have now commenced SAB ward rounds. There were 96 validated cases of *Clostridium difficile* (CDI) reported which was above the national rate. There was no evidence of cross transmission and work continued to investigate the risk factors.

Dr Armstrong went on to advise the Board of the current position with regards to the cases of infections associated with Ward 2A Royal Hospital for Children (RHC), related to the water system. There had been no trigger incidents since June 2018; however on the 5th September the Incident Management Team (IMT) was reconvened to discuss three additional cases of bacteraemia, likely to be associated with drainage issues in Ward 2A. As of 27th September, six additional cases had been identified. Following a risk assessment conducted by the Senior Management Team at the RHC a recommendation was made to, and subsequently approved by, the GGC Board

Directors to move patients from Ward 2A and 2B to suitable accommodation within the adult building. A robust and comprehensive planning process was undertaken and successfully completed prior to the move which took place uneventfully on 26th September. A detailed investigation of the water systems in 2A and 2B was currently being undertaken by an expert external company.

Mr Steele added that plans to dose the water supply with chlorine dioxide continued and a mobile dosing plant would be installed by the end of this week. Further plans to remove wash hand basins and taps, and to replace drainage systems were being taken forward, which would result in the requirement for extensive flooring repairs and redecorating.

In response to questions from Board members about the frequency of these incidents in similar facilities, Dr Armstrong explained that these incidents did not appear common.

Mr Brown thanked Dr Armstrong and Mr Steele for the update.

NOTED

119. CLINICAL AND CARE GOVERNANCE COMMITTEE – UPDATE

The Board considered and noted the minutes of the Clinical and Care Governance Committee Meeting of Tuesday 4th September [Paper No. CCG (M) 18/03].

Dr Lyons provided an overview to the Board on the main issues discussed at the meeting including a presentation on the medicines reconciliation immediate discharge letter project; the outcome of the joint inspection of adult support and protection in East Dunbartonshire; the rapid access clinic for paediatric dentistry at RHC and the emergency department child protection policy and process. Dr Lyons also noted Dr McGuire's update on the unannounced inspection of older people's inpatient care at Inverclyde Royal Hospital (IRH). The initial results of the inspection were disappointing and highlighted a number of issues including staff recruitment and retention. Dr Lyons noted that the Committee would undertake a deep dive review of the number of SAB cases and a further report on perinatal deaths was expected at the next Committee meeting.

Mr Brown thanked Dr Lyons for the update.

NOTED

120. CLINICAL GOVERNANCE ANNUAL REPORT

The Board considered the paper 'Clinical Governance Annual Report' [Paper No. 18/53] presented by the Medical Director, Dr Jennifer Armstrong.

The Board were content to accept the report and Mr Brown congratulated Dr Armstrong and the Committee on production of the report.

APPROVED

121. AREA CLINICAL FORUM – UPDATE

The Board considered the minutes of the Area Clinical Forum Meeting of Thursday 4th October [Paper No. ACF (M) 18/03].

Mrs Thompson provided an overview of the main topics discussed including Hospital Standardised Mortality Rates; Moving Forward Together Programme update; Winter Planning and Regional Planning. Mrs Thompson noted that members of the Forum were keen to contribute to the stakeholder engagement process for the Moving Forward Together Programme.

Mr Brown thanked Mrs Thompson for the overview and noted that the Board Annual Review would take place on 11th March 2019.

NOTED

122. FINANCE AND PLANNING COMMITTEE – UPDATE

The Board considered the minutes of the Finance and Planning Committee Meeting of Tuesday 2nd October 2018 [Paper No. FP (M) 18/05].

NOTED

123. AUDIT AND RISK COMMITTEE – UPDATE

The Board considered the minutes of the Audit and Risk Committee meeting of Tuesday 11th September 2018 [Paper No. AR (M) 18/04]. Mr MacLeod provided an overview of the main topics discussed including approval of the internal audit plan; discussion regarding the relationship between Board and IJB auditors, and plans to hold a meeting to discuss this in early November; and consideration of a report by Ms Vanhegan with regards to the Brexit Steering Group. Mr Macleod noted that it would be helpful to dedicate time at a Board Seminar in the new year to consider Brexit issues. **Secretary**

Mr Brown thanked Mr Macleod for the update.

NOTED

124. NHSGGC REVENUE AND CAPITAL REPORT

The Board considered the paper 'Revenue and Capital Report' [Paper 18/54] presented by the Director of Finance, Mr Mark White. The paper detailed the summary position to the end of August 2018 and Mr White advised that as at 31st August 2018, the Board reported expenditure levels of £16.3m over budget which was better than the initial trajectory forecast of £23.4m. Mr White went on to note that the Financial Improvement Programme (FIP) Tracker recorded projects totalling circa £51.2m on a FYE and £33.6m on a CYE. Given the need for contingency to cover pressures within the Acute Division and the use of non-recurrent funds to support the in-year financial challenge, the Board currently predicted a £23m financial gap for 2018/19.

Mr White provided further information on the work of the FIP project including continued work with the external advisors, the recruitment of 2 additional posts within the Management Office to ensure progress and work with the Moving Forward Together programme to understand how this fits within the overall financial picture. Mr White also noted the recent announcement by the Cabinet Secretary that as of 31st March 2018, NHS territorial boards would be required to set out finance and improvement plans that break-even over a 3 year period, currently plans were assessed over 1 year. Boards would be offered the flexibility to underspend or overspend by up to 1% of budgets in any one year. Mr White also noted that the Scottish Government would not seek to recoup brokerage paid to NHS territorial boards in the last five years. Mr White envisaged that NHSGGC would continue to progress current plans to reduce spend, increase savings and to operate within budget on an annual basis.

In response to questions from Board members regarding the 1% under/overspend, Mr White clarified that authority for this was delegated to both the accountable officer and the Board, therefore should the Board require to utilise this sanction, this would be brought to and considered by both the Finance and Planning Committee and the Board for approval in the first instance.

Mr Brown thanked Mr White for the update.

In summary, Mr Brown noted the current expenditure levels of £16.3m overspent, against the initial trajectory of £23.4m, the continued focus of the Financial Improvement Programme to identify areas of savings and realisation of such. Mr Brown noted a predicted £23m deficit moving into the second part of the financial year.

NOTED

125. STAFF GOVERNANCE COMMITTEE – UPDATE

Mrs McErlean noted that there had not been a further meeting of the Staff Governance Committee since the last Board meeting on 21st August. The next meeting of the Committee would take place on Wednesday 7th November.

NOTED

126. HUMAN RESOURCES AND ORGANISATIONAL DEVELOPMENT WORKFORCE UPDATE

The Board considered the paper 'Human Resources and Organisational Development – Workforce Update' [Paper No. 18/55] presented by the Director of HR and OD, Mrs Anne MacPherson. Mrs MacPherson advised of the recruitment of a record number of 458 newly qualified nurses. A new approach has been developed for induction of these staff, with nurses undertaking a professional induction, along with an organisational induction. Mrs MacPherson was hopeful that recruitment of these staff will address some of the issues with turnover, use of bank and agency staff, and contingency planning. Mrs MacPherson went on to inform Board members that a significant piece of work was undertaken in terms of doctors and dentists rotation placements, and it has been agreed that NHSGGC would be the host board for the West of Scotland.

Mr Brown thanked Mrs MacPherson for the update and invited questions from Board members.

In response to questions from Board members regarding the placement of the newly qualified nurses and current recruitment issues within specific areas such as Clyde, Dr McGuire explained that active recruitment in specific areas was undertaken resulting in the reduction of vacancies within Inverclyde from 11% to 2%. Mrs MacPherson provided a regular update on this to the Staff Governance Committee.

Mr Brown praised everyone involved in the recruitment of the newly qualified nurses.

NOTED

127. FOI ANNUAL REPORT

The Board considered the paper 'FOI Annual Report' [Paper No. 18/56] presented by the Deputy Head of Corporate Governance and Board Administration, Mr Graeme Forrester. Mr Forrester noted that the report detailed the statistical summary on the operation of the Freedom of Information (Scotland) Act 2002 and the Environmental Information (Scotland) Regulations 2004. Mr Brown noted the improvement in performance and congratulated Mr Forrester and team for their efforts.

NOTED

128. BOARD CALENDAR 2019

The Board considered the outline of proposed dates for Board and Committee meetings for 2019 [Paper No. 18/57]. It was agreed that the Board meeting scheduled for October 2019 would be moved to the 22nd October 2019, to avoid school holidays. Mr Forrester noted that Admin Control would be updated in due course with the meeting dates detailed within the paper. Board members noted a conflict on 25th June of the Inverclyde IJB and the Board meeting. Mr Forrester agreed to consider this, however noted that this may be unavoidable given the Board and IJB requirement to sign off financial accounts in June.

APPROVED

129. DATE AND TIME OF THE NEXT MEETING

Tuesday 18th December at 9.30am, The William Quarrier Centre, St Kenneth Drive, Govan, G51 4QD.

The meeting concluded at 3.55pm

NHSGG&C(M)19/01
Minutes: 1-27

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the William Quarriers Conference Centre, 20 St Kenneth Drive, Glasgow, G51 4QD
on Tuesday 19th February 2019

PRESENT

Mr J Brown CBE (in the Chair)

Ms J Grant
Dr J Armstrong
Cllr C Bamforth
Mr M White
Ms D McErlean
Mr S Carr
Cllr J Clocherty
Ms M Brown
Ms J Donnelly
Ms J Forbes
Mrs A Thompson
Ms R Sweeney
Cllr J McColl
Cllr M Hunter
Dr D Lyons
Mr J Matthews OBE
Mr I Nicolson
Dr M McGuire
Mr A MacLeod
Ms A Monaghan
Dr L de Caestecker
Mr A Cowan
Mr I Ritchie
Mr R Finnie
Ms S Brimelow OBE

IN ATTENDANCE

Mr G Forrester	Deputy Head of Corporate Governance and Administration
Ms E Vanhegan	Head of Corporate Governance and Administration
Mr W Edwards	Director of eHealth
Mrs A MacPherson	Director of Human Resources and Organisational Development
Mr T Steele	Director of Estates and Facilities
Mr K Hill	Director of Women and Children
Mr A McLaws	Director of Corporate Communications
Mr A Hunter	Director of Access
Ms L Long	Chief Officer, Inverclyde HSCP
Ms S Manion	Chief Officer, East Dunbartonshire HSCP
Ms J Murray	Chief Officer, East Renfrewshire HSCP
Ms B Culshaw	Chief Officer, West Dunbartonshire HSCP
Ms F MacKay	Head of Strategic Planning and Health Improvement, Renfrewshire
Ms S Devine	Associate Nurse Director Infection Control (To item 10)
Mr Z Barlow	Secretariat Officer (Minutes)

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Prof Dame A Dominiczak, Mr J Best and Cllr S Mechan.

NOTED

ACTION BY

2. DECLARATIONS OF INTEREST

Mr Brown invited Board members to declare any interests in any of the agenda items being discussed.

No declarations of interest were made.

NOTED

3. MINUTES

On the motion of Ms Sweeney, seconded by Mr MacLeod, the minutes from the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 18th December 2018 [Paper No. NHSGG&C (M) 18/06] were approved and accepted as an accurate record, subject to the following amendments:

Mr Finnie advised that he had submitted his apologies for the meeting.

NOTED

4. MATTERS ARISING FROM THE MINUTES

a) ROLLING ACTION LIST

The Rolling Action List [Paper No. 19/01] was considered.

The Board agreed the closure of nine actions recommended from the Rolling Action List.

Members raised concern regarding the timescales associated with the roll out of Project Search to all HSCPs. Ms Long advised that work was being taken forward, firstly in Inverclyde, working with colleges and the Local Authority. The project was in place in Glasgow City HSCP. Ms Long agreed to provide an update on progress to the Staff Governance Committee. **Ms Long**

NOTED

5. CHAIR'S REPORT

Mr Brown welcomed Ms Fiona MacKay, Head of Strategic Planning and Health Improvement, Renfrewshire HSCP; who attended on behalf of Mr David Leese, Chief Officer, Renfrewshire HSCP.

Mr Brown noted recent visits to the Royal Hospital for Children with Joe Fitzpatrick MSP, Minister for Public Health, Sport and Wellbeing and Shona Cardle, Chief Executive of the Glasgow Children's Hospital Charity.

Mr Brown and the Cabinet Secretary, Ms Jeane Freeman, visited the Teenage Cancer Trust at the Beatson WOSCC and the Helping Us Grow Group at the Neonatal Unit, Royal Hospital for Children, both of which provide a focussed approach towards patient centred care.

Mr Brown advised that he had hosted a reception celebrating the 40th Anniversary of the CLIC Sargent Glasgow Carol Concert at the Teaching and Learning Centre.

Mr Brown noted recent Committees and meetings he had attended including the Corporate Governance Steering Group, West of Scotland Health Sciences Oversight Board and a meeting with Professor Jackie Taylor, President of the Royal College of Physicians and Surgeons of Glasgow.

Mr Brown advised Board members of a number of meetings with the Cabinet Secretary, Ms Jeane Freeman, which had taken place since the last Board Meeting. Ms Freeman and Mr Brown, along with Board Chairs, had discussed infection control issues and the priorities for the year ahead, including improving performance and waiting times; sharing best practice across all Health Boards in Scotland; increasing the pace of integration; and improving mental health. Mr Brown advised of the Ministerial Strategic Group (MSG) Review of the Integration of Health and Social Care and that the Board would consider this further. He also advised members that Brexit preparations continued with ongoing communications to all staff and specific support available to non UK EU national staff.

Mr Brown reminded Board members of the recent request to complete the survey in respect of the Blueprint for Good Governance issued on 15th February, noting that the survey would close on 1st March 2019. Mr Brown advised of a workshop being arranged for the first week in April to include the results of the survey and discussions on the MSG Review of Health and Social Care Integration. Communication of the date and location would be shared with members following the Board meeting.

Mr Brown advised that interviews for three new Board members would take place on 27th February and 1st March 2019. The Board were keen to increase diversity and encouraged applications from members of all of the communities served by NHS Greater Glasgow and Clyde.

Mr Brown reminded Board members that the NHSGGC 2017-18 Annual Review would take place on 11th March 2019 at the Teaching and Learning Centre, Queen Elizabeth University Hospital.

NOTED

6. CHIEF EXECUTIVE'S REPORT

Ms Grant advised that she had been dealing with a number of operational issues since the last Board meeting and continued to support a variety of National and Regional work.

Ms Grant advised of the continued implementation of Best Start, which included the continuity of care model and the neonatal pilot within NHS Ayrshire. Ms Grant reported a positive visit with the Cabinet Secretary who commented on the excellent ongoing work.

Ms Grant noted a number of meetings she had attended since the last Board meeting including several regional planning meetings; the Delivery Plan engagement event where a number of initiatives were discussed; the Operational Performance Board;

National Integration Leadership Group meeting with the Chief Executive of NHS Ayrshire and Arran and Scottish Government colleagues to discuss working together across complex systems; and further eESS National System Implementation meetings.

Ms Grant noted that a number of appointments had been made, congratulating Mr Jonathan Best who had recently been appointed as the Chief Operating Officer; the role previously held by Mr Grant Archibald. Ms Isobel Neil had been appointed as the new North Sector Director. Mr Arwel Williams had been appointed as the Director of Diagnostics. Ms Fiona McKay had been appointed as the Associate Director of Planning and Ms Gail Caldwell had been appointed as the Director of Pharmacy. Ms Grant also congratulated Mr Gary Jenkins on his recent appointment as Chief Executive of the State Hospital and thanked Mr Ally McLaws, who was resigning as Director of Communications, for his support and contributions to the organisation.

Ms Grant reported that a further unannounced inspection had taken place at the Cowlairs Decontamination Unit at the beginning of February, which resulted in a positive report with significant progress noted. There was one minor recommendation. Inspectors had been impressed with the swift action undertaken by the organisation to address the issues. Further detail of the ongoing internal investigation would be provided to the Acute Services Committee. Ms Grant noted thanks to Mr Tom Steele and the Estates and Facilities Team, for their ongoing efforts in relation to this.

A number of key performance reviews with HSCP's had been undertaken which proved to be useful in discussing key issues and how to improve cross system working.

Ms Grant and Mrs Susan Manion, Chief Officer, East Dunbartonshire HSCP, had attended the Strategic Inspection of Adult Services undertaken by the Care Inspectorate in East Dunbartonshire; the feedback of which was awaited.

Ms Grant noted a number of meetings she had attended locally, including a meeting with the Editor of the Herald to discuss future strategic work; a number of MSP's meetings; and meetings with the Cabinet Secretary and Mr Paul Gray, Director General of NHS Scotland, regarding local operational issues at the QEUH and the Teenage Cancer Trust at the Neonatal Unit at the QEUH.

Ms Grant highlighted her visit to the new Intensive Care Unit at the Royal Alexandra Hospital and was pleased to note an impressive facility.

Mr Brown thanked Ms Grant for the update and invited questions from Board members.

In response to questions from Board members with regards to the Annual Review, Ms Grant advised that the format of the review would remain substantially the same as in previous years, with a public session in the afternoon. She noted that there would be a private session conducted with the Chairman, the Chief Executive, the Cabinet Secretary and Scottish Government officials.

NOTED

7. PATIENTS STORY

ACTION BY

Dr McGuire, Director of Nursing, introduced a short film which featured a patient's recent experience of the Teenage and Young Adult Team and the Teenage Cancer Trust.

Mr Brown wished to note thanks on behalf of the Board to the patient for providing such clear and practical feedback.

NOTED

8. HEALTHCARE QUAILTY STRATEGY

The Board considered the new Healthcare Quality Strategy paper "The Pursuit of Excellence" [Paper No. 19/02] presented by the Director of Nursing, Dr Margaret McGuire.

Dr McGuire advised that a Healthcare Quality Review group had been established to review existing governance and accountability processes to support the delivery of the Strategy. The Strategy would be accompanied by a set of deliverables and an action plan on an annual basis as part of ongoing engagement with patients, carers, families and staff.

Dr McGuire advised that the Strategy was in line with the national quality ambitions focussed on person centred care, effective care, and a safe environment for healthcare. She went on to highlight the key areas of focus for the coming year.

Dr McGuire highlighted the importance of governance arrangements of the Strategy and linking with other strategies and programmes, including the Digital Strategy, Public Health Strategy and the Moving Forward Together Programme. Dr McGuire stressed that the success of the Strategy would require a whole team approach involving both clinical and non clinical staff, towards the delivery of quality care of our patients.

Mr Brown thanked Dr McGuire for the update and asked that consideration be given to highlighting the accessibility of services in the Strategy. Mr Brown invited questions from Board members. **Director of Nursing**

In response to suggestions from Board members, Dr McGuire agreed to include information within the Strategy about the NHSGGC Whistleblowing Policy under Safe Care; clarity on the shared decision making process and best practice, given the sharing best practice priority set by the Cabinet Secretary for all Board's across Scotland; and highlight the importance of partnership relationships between patients and staff. **Director of Nursing**

Following discussion, the Board agreed to approve the Strategy in principle, subject to completion of an Equalities Impact Assessment (EQIA). The Board agreed to delegate final approval of the Strategy to the Clinical and Care Governance Committee. **Director of Nursing**

APPROVED

9. QUEEN ELIZABETH UNIVERSITY HOSPITAL CAMPUS UPDATE

ACTION BY

Ms Grant updated the Board on recent issues experienced at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC).

Ms Grant advised that immediate action and monitoring had been undertaken on each occasion to ensure patient safety and it was recognised that further co-ordinated action was required to address public concern.

Ms Grant described the three main work streams that she had commissioned including a review of Estates, Facilities and environmental issues in respect of the QEUH and RHC; a review of capacity and flow to assess the current position against the original model and planning assumptions for the hospitals; and a review of clinical outcomes over the period to provide assurance.

Ms Grant advised that a Programme Board would be established, chaired by herself and comprising of the leads of the three work streams and other key members of senior staff.

In addition, it was noted that the Cabinet Secretary had announced an independent external review of the QEUH and RHC which would be set up under the Britton principles and include the appointment of an Independent Chair. It was underlined that the work of the internal review was complimentary to that of the independent review.

Mr Brown thanked Ms Grant for the update and invited questions and comments from Board members.

In response to questions from members, it was advised that timescales for the reviews would be made explicit through the relevant Governance Committees for each work stream and that a final report would be presented to the Board in due course. This would be included on forward planners.

Secretary

Thanks were noted to the Communications Department who had been in continuous contact with the media throughout this time.

Members were pleased to note the organisation's good work over the last few months to address the issues and expressed gratitude for the continued work and continued actions to provide safe, reliable and professional healthcare.

NOTED

10. HEALTHCARE ASSOCIATED INFECTION REPORT

The Board considered the paper "Healthcare Associated Infection Report" [Paper No. 19/04] presented by the Medical Director, Dr Jennifer Armstrong.

The report highlighted a total of 90 validated cases of Staphylococcus Aureus Bacteraemia (SAB) infections for Quarter 3 from July to September 2018 which was below the national rate. Reduction of infections remains a priority and the SAB Group continued to meet on a regular basis.

There were 111 validated cases of Clostridioides (formerly Clostridium) Difficile (CDI)

ACTION BY

reported which was above the national average.

Dr Armstrong advised that investigations were continuing into two isolated cases of Crytococcus neoformans. In addition, samples from two patients tested positive for Mucormycosis at the QEUH, one patient required treatment for the infection while the other was not infected but the bacteria was present on their skin.

Investigations were ongoing into the potential source of the fungi; no new cases of either had been reported since the 18 January 2019.

Dr Armstrong advised that three cases of an unusual strain of Staphylococcus aureus Bacteraemia had been found in very ill, extremely premature, babies at the Princess Royal Maternity Hospital.

On the 29 January 2019, NHS Greater Glasgow and Clyde invoked the National Support Framework for NHS Boards and Health Protection Scotland were formally invited to review the actions in relation to the incident. HPS were previously invited and attended the Infection Management Team meeting held on the 28 January 2019. A formal report from HPS will be issued to NHSGGC in due course.

All babies in the unit had been screened, none had been found to be positive for the particular type of Staphylococcus aureus Bacteraemia as of 4 February 2019. Screening would continue weekly for the agreed 4 week period.

In response to questions from Board members, it was advised that staff were not routinely screened, however in light of recent cases, it had been decided that staff would be screened to further mitigate the risk of infection.

Dr Armstrong advised that three patients who had been in Intensive Treatment Unit (ITU) at the Royal Alexandra Hospital were tested positive for Stenotrophamonas maltophilia. Additional screening of patients and the environment was carried out on 8th February and one additional case was identified. No additional cases have been identified as of 11 February 2019.

It was advised that there was an unannounced Healthcare Environment Inspectorate (HEI) visit to QEUH and RHC between 29 January and 1 February 2019. Dr McGuire advised that the results had just been received and, overall, were positive. However, Dr McGuire noted that a number of improvements were required. Dr McGuire encouraged members to read the report and note of the ongoing improvements being made.

Dr Lyons highlighted that the MRSA screening Clinical Risk Assessment (CRA) uptake table of figures had not been considered by the Clinical and Care Governance Committee prior to the Board meeting. Dr Lyons queried whether the Board could remit some of the issues to the Committee to keep in line with Board processes. It was agreed that the Clinical and Care Governance Committee would review and discuss the figures and Healthcare Associated Infection report at the next meeting. This would be included on the forward planner.

Secretary

Further clarity was requested in relation to the hand hygiene bullet point on page 11 of the document, as Board members felt that the actions were unclear.

The Board were content to note the report and Mr Brown thanked Dr Armstrong for the update.

NOTED

11. CLINICAL AND CARE GOVERNANCE COMMITTEE UPDATE

The Board noted the draft minutes of the Clinical and Care Governance Committee Meeting [C&CG (M) 18/04] which took place on 11th December 2018.

Mrs Brimelow provided an overview of the key topics discussed. The Committee were content that robust mechanisms were in place to address all significant issues.

The next meeting would take place on 5th March.

Mr Brown thanked Ms Brimelow for the update.

NOTED

12. AREA CLINICAL FORUM UPDATE

The Board noted the approved minutes of the Area Clinical Forum [ACF (M) 18/05] which took place on 6th December 2018.

Mrs Thompson advised the Board of the topics discussed at the most recent meeting held on 7th February 2019 including, the development of better links with HSCPs and the Chair's recent meeting with Chief Officers; Safe Staffing Legislation; the Health Care Quality Strategy; infection control issues and the Moving Forward Together Programme. Presentations were also received on implementation of the Digital Strategy; and from Pharmacy colleagues in relation to work with diabetic patients and Acute Care Specialists.

Mrs Thompson advised preparation for the Boards Annual Review was also underway.

Mr Brown thanked Mrs Thompson for the update and commented positively on the ongoing relationship building with HSCPs.

NOTED

13. ACUTES SERVICES COMMITTEE UPDATE

The Board noted the draft minute of the Acute Services Committee [ASC (M)19/01] Meeting of 15th January 2019.

Mr Finnie provided an overview of the topics discussed. The Board were advised that the Integrated Performance report was a key focus of the meeting, and that the level and volume of activity increased the challenge for teams to meet the Scottish Government targets.

The Financial Monitoring Report was also considered in detail.

Mr Brown thanked Mr Finnie for the update and commented positively on the

ACTION BY

Waiting Times Initiative.

NOTED

14. NHSGGC INTEGRATED PERFORMANCE REPORT

The Board noted the paper "NHSGGC Integrated Performance Report" [Paper No.19/05] presented by Mr Mark White, Director of Finance.

Mr White highlighted the areas meeting or exceeding target including access to a range of services including Drug and Alcohol Treatment; Alcohol Brief Interventions; Smoking Cessation; Psychological Therapies; and IVF Treatment. The number of C-Difficile cases remained positive against target. Overall financial performance remained within trajectory and ongoing performance represented a significant improvement on the same position reported the previous year.

Areas requiring improvement continued to be waiting times for the Cancer 62 Day target, compliance with the Treatment Time Guarantee, access to Child and Adolescent Mental health services, 18 week Referral to Treatment target, and number of Staphylococcus aureus Bacteraemia (SAB) infections.

Mr Brown thanked Mr White for the update and invited comments and questions from Board members.

In response to Board Members concerns about the GP Out of Hours service, Ms Grant advised that two reviews had been commissioned. Ms Grant agreed to provide an update on the GP Out of Hours service and time scales for implementation to the Finance and Planning Committee. **Chief Executive**

Mr Jenkins updated members on the 62 day cancer position. Mr Jenkins advised that work continued to get schedule earlier treatment appointments for patients. Challenges remained within Urology, where a number of measures had been put in place. A review would be undertaken to ascertain if the changes made to the pathway had improved 62 day performance.

Mr Brown noted the A&E performance improvement in comparison to the previous year, which was 85.1% in December 2017 and 89.6% in December 2018.

Dr McGuire provided an update on delayed discharges. Ms Morag Brown raised concern regarding the number of delayed discharges within Mental Health. Ms Brown suggested that a paper on delayed discharge due to be presented to the Acute Services Committee, be brought to the Finance and Planning Committee instead, and felt that it was important to include Mental Health delayed discharges. Ms Grant agreed to consider the governance process for reporting Mental Health delayed discharges to ensure that the most appropriate Committee received the relevant information for scrutiny.

Mr Brown highlighted the number of bed days lost across NHSGG&C. Mr Brown questioned the reasons for delayed discharge and the delay in care home placements, and asked if there was a resource issue for HSCPs causing the delays. Mr Brown was advised that there was not a resource or financial issue however some patients have complex care needs, requiring more planning which could cause delays.

ACTION BY

In respect of attendance, Mrs MacPherson indicated the Board's overall sickness absence rate had risen slightly by 0.8% compared to the end of the previous quarter in September 2018, and was in a comparable position with sickness absence in December 2017.

The Board noted that an Attendance Improvement Plan, designed to improve staff attendance at work, had been developed, following a recent internal audit. All Directors, Chief Officers and Heads of People and Change had agreed trajectories for their service areas, to improve staff attendance and these will be reviewed and monitored as part of the Performance Review Group (PRG) meetings, in addition to weekly management monitoring arrangements.

Boards members commented on the issues faced by staff, managers and teams, and emphasised the importance of robust processes being in place to support managers.

In response to Mr Brown's question regarding low uptake rates of staff flu vaccinations and how these could be improved, Mrs MacPherson advised that flu prevalence had not been as high as it had been in the previous year. There was ongoing work being undertaken to consider ways in which uptake of vaccinations could be improved. It was acknowledged that this would be discussed further at the Staff Governance Committee. This would be included on the forward planner. **Secretary**

Mr Brown thanked Mr White for the update.

NOTED

15. CHILD AND ADOLESCENT MENTAL HEALTH SERVICES

Mr McLeod, Head of Specialist Children's Services updated the Board on Child and Adolescent Mental Health Services (CAMHS) performance progress.

Mr McLeod advised that the Scottish Government had provided additional funding of £4m nationally for CAMHS to improve capacity and improve RTT performance.

The Board were asked to note the recent improvements in CAMHS performance against the recent increase in demand. To further improve performance, a CAMHS Improvement Plan has been created. The Plan would help ensure all appropriate referrals were seen on time, help reduce Did Not Attend (DNA) rates and improve RTT performance.

Mr Brown thanked Mr McLeod for the update and asked for assurance that the same quality of care was maintained following the reported positive improvement rates in performance against an increase in demand. Mr McLeod assured the Board that there had been no detriment to the quality of care provided, referring to measures including feedback from patient experience questionnaires and number of complaints. Mr McLeod advised that the introduction of text reminders for patients had positively impacted on attendance rates.

NOTED

16. MOVING FORWARD TOGETHER UPDATE

The Board considered the paper "Moving Forward Together Programme Update" [Paper No. 19/06] presented by the Medical Director, Dr Jennifer Armstrong.

Dr Armstrong advised the Board that discussions were ongoing regarding appointment to the Programme Director role for Moving Forward Together (MFT), following Mr Best's appointment to the post of Chief Operating Officer.

Dr Armstrong advised Board members that a detailed update on MFT had been provided to the Finance and Planning Committee on the 5th February 2019.

Dr Armstrong reported to the Board on progress made during the implementation phase of the MFT Programme. The work streams had developed a number of Project Initiation Documents, detailing focussed cases for change which would be submitted to the MFT Executive Group for consideration. Wider Workstream Reference Groups for each work stream were undertaking a series of sessions during February and March, focussing on the identification of further cases for change and co-ordination of existing projects and improvement work.

The Programme Board and the Executive Group continue to meet on a regular basis.

HSCP colleagues and the Patient Stakeholder Reference Group (PSRG) had been asked to identify other local opportunities to present to community groups to raise awareness, develop links and have initial conversations about the Programme. Sessions that had already taken place were reported to have been positive.

Mr Brown thanked Dr Armstrong for the update. Mr Brown was pleased to note ongoing discussions with the public and the public understanding of the need for change, to correlate with the Cabinet Secretary's priorities.

Mr Brown invited comments and questions from Board members.

Mr Matthews wished to emphasise the importance of the public engagement sessions to consult with the public on the MFT Programme, as well as delivering information on Public Health, Acute Services and the GP Contract.

NOTED

17. NHSGG&C PUBLIC HEALTH SCREENING PROGRAMME ANNUAL REPORT 2017-18

The Board noted the paper "NHSGGC Public Health Screening Programme Annual Report 2017-18" [Paper No. 19/06] presented by the Director of Public Health, Dr Linda de Caestecker.

The report included analysis by socio-economic group, among young people with learning disabilities, mental illness and by ethnicity. From 2019, geographical mapping of the uptake rates for Cervical, Bowel, Abdominal Aortic Aneurysm and Diabetic Retinopathy Screening programmes would be available to enable targeted local delivery.

Dr de Caestecker advised of high uptake screening which included newborn bloodspot screening and universal newborn hearing screening. Saturday morning smear test

clinics were working well and received a higher uptake than anticipated. Dr de Caestecker advised that there was ongoing work to improve the uptake of people living with disabilities.

Mr Brown thanked Dr de Caestecker for this piece of work and invited comments and questions from Board members.

In response to questions from Board members, Dr de Caestecker advised that, despite efforts, there had been little improvement in the uptake for people with learning disabilities. Work was ongoing with other health boards and at national committees to improve understanding of the issues faced by this vulnerable group and to identify improvements that could be made to increase uptake.

Ms Brown thanked Dr de Caestecker and Dr Crighton for their continued efforts to highlight the need for an update of the national IT system for breast screening.

NOTED

18. PUBLIC HEALTH COMMITTEE – UPDATE

The Board noted the draft minutes of the Public Health Committee Meeting [PH(M)19/01] which took place on 30 January 2019.

Mr Matthews, Chair of the Public Health Committee, noted that discussion took place about the Adult Health and Wellbeing Survey Report which takes place every 3 years. Mr Matthews was pleased to report positively on the survey and suggested that Board members review this.

Mr Matthews highlighted the Public Health Summit recently hosted by Glasgow City which was well attended by Board members.

Mr Brown thanked Mr Matthews for the update and advised that the positive and impressive work GG&C were doing to improve public health was recognised nationally.

NOTED

19. FINANCE AND PLANNING COMMITTEE UPDATE

The Board noted the draft minutes of the Finance and Planning Committee Meeting [F&P(M) 19/01] which took place on 5th February 2019.

Mr Brown noted the topics reviewed by the Committee including the Moving Forward Together Programme; Capital & Revenue reports; a Vascular services update and an update on the Yorkhill site.

NOTED

20. AUDIT AND RISK COMMITTEE UPDATE

The Board noted the draft minutes of the Audit and Risk Committee Meeting [ARC (M) 18/05] which took place on 11th December 2018.

Mr McLeod noted that he had met with internal auditors, along with the Chair.

Mr McLeod advised that a number of audits had been undertaken and would be discussed at the next meeting on the 12th March 2019.

Mr Brown thanked Mr McLeod for the update and also thanked him for his ongoing support to NHS Tayside Audit Committee.

NOTED

21. NHSGGC REVENUE AND CAPITAL REPORT

The Board considered the paper "NHSGGC Revenue and Capital Report" [Paper No. 19/08] presented by the Director of Finance, Mr Mark White.

Mr White provided a summary of the Month 9 financial position. He noted that as of 31st December 2018, the Board reported expenditure levels of £19.3m over budget. The Board had factored in £24.2m of non-recurring relief to support the financial position.

Mr White provided a breakdown of the financial position, noting that Acute Division reported an over spend of £35.7m. Of the £35.7m over spend reported, £31.9m related to unachieved savings, £2.0m related to pay and £1.4m was associated with non-pay.

Mr White noted pressures of £3.1m associated with medical salaries and £2.4m associated with nursing salaries. Mr White recognised efforts to improve this.

Corporate Directorates reported an expenditure overspend of £10.5m. Although expenditure for pay and non-pay was running below budget, a shortfall of £12.3m against Financial Improvement Programme (FIP) savings was reported.

Partnerships reported an under spend of £2.7m. It was expected that all IJBs would achieve a breakeven position on the health budget for 2018/19.

Mr White went on to note the main pressure areas of over spend which were within mental health and specialist children's services.

The Financial Improvement Programme (FIP) tracker recorded projects totalling £56.3 on a full year effect (FYE) and £36.6m on a current year effect (CYE).

Mr White noted main cost pressures including £1.5m allocated to address the water issue at the Queen Elizabeth University Hospital campus, £1.5m identified for demolition costs following the recent fire at the Stobhill Hospital site, an additional £4m accounted for within the revised Financial Plan for additional winter pressures, and an additional £2.2m accounted for within the revised plan to address additional compensation claims in year.

Mr White went on to note that the National New Medicines Fund was expected to yield £2m more than anticipated. Additional discount claw back and rebates of £1.5m were also expected in relation to Acute prescribing.

The Director of Finance was currently predicting a £2.5m deficit at 31 March 2019, however Mr White was confident that the Board would achieve a break even position at the year end.

Mr White went on to note the Capital position. £59m of allocated projects continue including those related to Glasgow Royal Infirmary, Queen Elizabeth University Hospital Campus and Royal Alexandra Hospital.

In conclusion, the month 9 financial position is £19.3m over budget, well ahead of the initial trajectory of £40m. The organisation would continue with cost containment efforts and the FIP programme to achieve savings, with continued discussions with Scottish Government colleagues in relation to levels of support.

Mr Brown thanked Mr White and colleagues for their efforts and noted the significant achievements made, which provided assurance to the Board going into the next financial year.

NOTED

22. INITIAL FINANCIAL OUTLOOK - 2019/20

The Board considered the paper "2019/20 Financial Outlook" [Paper No. 19/09] presented by the Director of Finance, Mr Mark White.

Mr White advised that the Scottish budget was announced in the Scottish Parliament on 12th December 2018. An additional £149m, would be invested across core areas.

NHSGGC's financial plan has set out the Board's financial position including delegated health services, managed by Integrated Joint Boards (IJBs). However, to highlight the scale of the challenge to be addressed by the Acute Division and Corporate Departments the shares of uplifts and expenditure to be managed by IJBs need to be deducted. IJB's would receive 1.8% on their base recurring budgets plus a share of the additional allocation of £16.3m for pay awards, based on share of pay costs.

It was expected that the initial headline financial challenge for 2019/20 would be £85.7m, significantly less than in recent years. Work continued to determine the final figure for efficiency savings required for 2019/20.

Mr Brown thanked Mr White for the update.

NOTED

23. STAFF GOVERNANCE COMMITTEE UPDATE

The Board noted the draft minutes of the Staff Governance Committee Meeting [SCG (M)19/01] of 5th February 2019.

Ms Brown provided an overview of the topics considered by the Committee. Staff

ACTION BY

Governance Action Plan presentation updates were received from East Dunbartonshire HSCP and the eHealth Directorate. The Committee received a health and safety compliance update and an update on the staff flu vaccination campaign which reported a 45% uptake.

Ms Brown highlighted the ongoing focus by the Staff Governance Committee on compliance with statutory and mandatory training. Managers had been reminded to ensure all staff have access to and complete the training modules.

Ms Brown advised that she had requested to meet with Mr Brown and Ms Grant to discuss the Whistleblowing Policy prior to her departure.

Mr Brown thanked Ms Brown for the update.

NOTED

24. STAFF GOVERNANCE ANNUAL REPORT

The Board considered the paper "Staff Governance Committee Annual Report 2017-18" [Paper No. 19/10] presented by the Director of Human Resources and Organisational Development, Mrs Anne MacPherson.

Mrs MacPherson highlighted the key aspects of the paper which included the new Turas platform the continued implementation of iMatter and the employability agenda.

The ongoing work regarding the culture framework was considered in the context of the dignity at work survey. Mr Carr advised that ensuring positive relationships within the workplace was crucial. Ms Grant, Mrs MacPherson and Ms McErlean agreed to work on an approach to this and to report back to the Staff Governance Committee.

The Board requested that attendance management be included within section 10 of the paper under future priorities. **Director of HR and OD**

Following questions from Ms Morag Brown regarding annual reports, Mr Brown agreed to consider the requirement for all sub committees to produce an annual report, as part of the ongoing governance review being led by Ms Elaine Vanhegan, Head of Corporate Governance and Administration.

NOTED

25. NHSGG&C CORPORATE OBJECTIVES

The Board considered the paper "NHSGGC Corporate Objectives 2019-20" [Paper No. 19/11] presented by the Chief Executive, Jane Grant.

Ms Grant presented the Corporate Objectives to the Board for approval.

Members agreed to approve the objectives subject to minor amendments.

The Chair thanked Ms Grant for the early presentation of the Corporate Objectives for

2019/20.

NOTED

26. BOARD GOVERNANCE UPDATE

Ms Vanhegan, Head of Corporate Governance and Administration advised that an update would be presented to the Board in June detailing the Annual Review of Corporate Governance. This was to allow time to consider the requirements of the work being led nationally by the Corporate Governance Steering Group in respect of the Blueprint for Good Governance.

The Chair thanked Ms Vanhegan and highlighted her ongoing work with developing Board and Committee processes to ensure consistent and accountable decision making, and in ensuring appropriate Committee membership while Board member recruitment processes were underway.

NOTED

27. VALEDICTORY

Mr Brown advised the Board that Ms Morag Brown was due to retire as Non Executive Board Member, and as such this would be Ms Brown's last Board meeting.

Mr Brown highlighted Ms Brown's contributions as Co-Chair of the Staff Governance Committee; Chair of East Renfrewshire IJB; Member of Renfrewshire IJB; Member of the Acute Services Committee; Member of the Finance and Planning Committee; Whistleblowing Champion; involvement with the Beatson Charity Forum; and Member of the Scottish Patient Safety Programme for the North Sector.

Mr Brown noted thanks on behalf of the Board to Ms Brown who had shown commitment and dedication to the Board as a Non-Executive member since 1st April 2011. Ms Brown's contributions would be missed and the Board wished Ms Brown well for the future.

NOTED

DATE AND TIME OF THE NEXT MEETING

Tuesday 16th April 2019, 9.30am, The William Quarrier Centre, St Kenneth Drive, Govan, G51 4QD.

The meeting concluded at 4.05pm

NHSGG&C(M)19/02
Minutes: 28 - 58

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the William Quarriers Conference Centre, 20 St Kenneth Drive, Glasgow, G51 4QD
on Tuesday 16th April 2019

PRESENT

Mr J Brown CBE (in the Chair)

Ms Jane Grant
Dr Jennifer Armstrong
Cllr Caroline Bamforth
Mr Mark White
Ms Dorothy McErlean
Mr Simon Carr
Cllr Jim Clocherty
Ms Margaret Kerr
Ms Jeanette Donnelly
Ms Jacqueline Forbes
Mrs Audrey Thompson
Ms Rona Sweeney
Cllr Jonathan McColl
Ms Amina Khan
Dr Donald Lyons
Mr John Matthews OBE
Cllr Iain Nicolson
Dr Margaret McGuire
Mr Allan MacLeod
Ms Anne Marie Monaghan
Dr Linda de Caestecker
Mr Alan Cowan
Mr Iain Ritchie
Mr Ross Finnie
Ms Susan Brimelow OBE

IN ATTENDANCE

Mr Graeme Forrester	Deputy Head of Corporate Governance and Administration
Ms Elaine Vanhegan	Head of Corporate Governance and Administration
Mr William Edwards	Director of eHealth
Mrs Anne MacPherson	Director of Human Resources and Organisational Development
Mr Tom Steele	Director of Estates and Facilities
Mr Kevin Hill	Director of Women and Children
Mr Ally McLaws	Director of Corporate Communications
Ms Sandra Bustillo	Associate Director of Corporate Communications
Ms Louise Long	Chief Officer, Inverclyde HSCP
Mr David Leese	Chief Officer, Renfrewshire HSCP
Mr David Williams	Chief Officer, Glasgow City HSCP
Ms Beth Culshaw	Chief Officer, West Dunbartonshire HSCP
Ms Sandra Devine	Associate Nurse Director Infection Control (To item 10)
Mrs Geraldine Mathew	Secretariat Manager (Minutes)

ACTION BY

28. APOLOGIES

Apologies for absence were intimated on behalf of Cllr Mhairi Hunter, Cllr Iain Nicolson, Cllr Sheila Mechan, and Prof Dame Anna Dominiczak.

NOTED

29. DECLARATIONS OF INTEREST

Mr Brown invited Board members to declare any interests in any of the agenda items being discussed.

Dr Lyons wished to declare an interest in relation to Item 15, given his role as a Medical Member of the Mental Health Tribunal for Scotland. However, given that Dr Lyons is not directly involved in Greater Glasgow and Clyde cases, the Board were content to note this.

NOTED

30. MINUTES

On the motion of Mr Ritchie, seconded by Ms Monaghan, the minutes from the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 19th February 2019 [Paper No. NHSGG&C (M) 19/01] were approved and accepted as an accurate record.

NOTED

31. MATTERS ARISING FROM THE MINUTES

a) ROLLING ACTION LIST

The Rolling Action List [Paper No. 19/13] was considered.

The Board agreed to the recommendation of the closure of 7 actions from the Rolling Action List.

In addition, in response to questions from Board members in relation to Item 112 – Hub Scheme, Mr Steele provided an update on progress of the Clydebank Hub Scheme, noting that the project was progressing well and estimated that final sign off would be concluded in summer 2019.

Dr Armstrong corrected Item 138b – West of Scotland Regional Planning Systemic Anti Cancer Therapy. She highlighted that further information including case studies and data would be presented to a future Board meeting, and not a Full Business Case as stated in the Rolling Action List. The Board were content to accept this amendment. **Secretary**

NOTED

32. CHAIR'S REPORT

Mr Brown provided an overview to the Board on his recent engagements since the last meeting.

Mr Brown attended a visit to the Imaging Centre for Excellence, accompanied by, the Deputy First Minister, Mr John Swinney MSP, and Prof Dame Anna Dominiczak.

Mr Brown reported that he had attended the official opening of the new Gorbals Health and Care Centre on Wednesday 3rd April 2019, accompanied by Ms Jeane Freeman, Cabinet Secretary, Ms Jane Grant Chief Executive, Cllr Mhairi Hunter and Mr David Williams, Chief Officer, Glasgow City HSCP. The Centre opened its doors to the public in January 2019 and provides local residents with a wide range of modern health and care services under one roof.

Mr Brown was pleased to attend the official opening of the new state-of-the-art Intensive Care Unit (ICU) at Royal Alexandra Hospital (RAH) in Paisley. Mr Brown was very impressed with the design and the air of space, light and calm within the Unit.

Board members recently took part in a productive Board Development session focused on Corporate Governance, on 2nd April 2019. A Board briefing session was also undertaken regarding the Queen Elizabeth University Hospital campus.

Mr Brown agreed to circulate the Cabinet Secretary's formal letter of response following the Annual Review 2017/18 held on 11th March 2019. **Board Secretary**

Mr Brown attended a West of Scotland Collaboration Event, as well as a meeting of the Health and Sciences Network Oversight Group.

Mr Brown was invited to provide a lecture on Corporate Governance recently to 5th year medical students, as part of the Preparing for Practice (including Clinical Governance) Course at the University of Glasgow.

A number of engagements were planned for May, including a symposium hosted by the Royal College of Physicians of Edinburgh on 10th May 2019, which will focus on governance and quality of health care; and a meeting with the Royal College of Physicians and Surgeons of Glasgow; the General Medical Council (GMC); the Scottish Government; NHS Education for Scotland (NES); and the Universities of Glasgow and Dundee, to discuss the way forward in designing a Clinical Leadership Development Programme.

Mr Brown also provided an update on the work of the National Corporate Governance Group who are considering topics including governance systems; recruitment, skills and development of Board members; baseline surveys; and action planning, to improve governance across NHS Scotland.

Mr Brown noted that the recruitment process was underway to appoint the Chair of NHS Tayside. He confirmed that he would remain in post or

Interim Chair until a permanent appointment was made by the Scottish Government.

NOTED

33. CHIEF EXECUTIVE'S REPORT

The NHSGG&C Annual Review of 2017/18, took place on 11th March 2019. Ms Grant thanked all those who participated for their contributions and was pleased to report that the event received positive feedback. A number of actions were being progressed following the formal feedback received from the Cabinet Secretary.

Ms Grant noted a number of meetings she had attended including the National Operational Performance Board; Joint Meeting of the Chairs and Chief Executives; Glasgow Centre for Population Health Meeting; and a meeting of the Glasgow Centre of Voluntary Organisations and 3rd Sector.

Ms Grant also noted that she had accompanied Mr Brown to the opening of the new Gorbals Health and Care Centre and the new Intensive Care Unit at Royal Alexandra Hospital.

Good progress had been made in relation to the Corporate Management Team Development programme.

Mr Brown thanked Ms Grant for the update.

NOTED

34. PATIENTS STORY

Dr McGuire, Director of Nursing, introduced a short film which featured a carers recent experience of care within Acute settings for patients with learning disabilities.

Mr Brown wished to note thanks on behalf of the Board to the carer and family for providing useful and constructive feedback. Dr McGuire added that a number of actions were underway to improve awareness and training of staff to address the issues raised in relation to person centred care, person centred visiting and time to listen. Dr McGuire was committed to ensuring that the feedback and improvements required were embraced throughout the organisation.

NOTED

35. PARTICIPATION IN NHSGGC SCREENING PROGRAMMES AMONGST PEOPLE WITH LEARNING DISABILITIES 2015-2018

The Board considered the paper 'Participation in NHSGGC Screening Programmes amongst people with learning disabilities' [Paper No. 19/14] presented by the Director of Public Health, Dr Linda de Caestecker. The paper provided further information requested by Board members, following presentation of the NHSGGC Annual Screening Report for 2017-2018, at the February 2019 Board meeting. The report detailed the participation data for a number of screening programmes including Abdominal Aortic Aneurism Screening; Bowel Screening; Cervical Screening; and Diabetic Retinopathy Screening.

Mr Brown thanked Dr de Caestecker for providing further information as requested by Board members and invited questions.

In response to comments from Board members in relation to the information contained within page 5 of the report regarding colonoscopy procedures, Dr de Caestecker agreed to consider improved delivery of information to patients regarding colonoscopy procedures and process of gaining consent.

Following discussion regarding collection of data within primary care given the new GP Contract, Dr de Caestecker agreed to work with Mr David Leese, Chief Officer, Renfrewshire HSCP, to protect the collection, quality and completeness of data for this vulnerable group of individuals. The Public Health Committee will oversee an approach which improves data collection for this patient group.

Mr Brown thanked Dr de Caestecker for the update on the matters raised at the Board Meeting in February.

NOTED

36. PUBLIC HEALTH COMMITTEE UPDATE

Mr John Matthews, Chair of the Public Health Committee, advised Board members that the next meeting of the Committee would take place on Wednesday 17th April. Mr Matthews noted a number of initiatives underway in relation to public health, including an employment pilot and the Festival of Ageing. Mr Matthews was keen to discuss with the Committee ways in which these initiatives could be tracked. Mr Matthews was pleased to note the appointment of a Public Health Lead within Police Scotland. Mr Malcolm Graham, Assistant Chief Constable, will undertake the role and Mr Matthews will shortly meet with Mr Graham and Dr de Caestecker.

Mr Brown thanked Mr Matthews for the update and wished to commend Mr Matthews, Dr de Caestecker and the Public Health Committee, for their efforts to facilitate and join up many public health initiatives to ensure the success of the Public Health Strategy.

NOTED

37. MOVING FORWARD TOGETHER

The Board considered the paper 'Moving Forward Together: Implementation Phase Update' [Paper No. 19/15] presented by the Medical Director, Dr Jennifer Armstrong.
The paper provided an update on progress made in the implementation phase of the Moving Forward Together Blueprint for the Future Delivery of Health and Social Care, approved by the Board on 26th June 2018.

Dr Armstrong highlighted a number of areas being progressed, including development of a case for change for complex cancer care, systemic anti-cancer therapy, and the major trauma network model. Dr Armstrong noted that these would be presented to the Board in June 2019.

Dr Armstrong also noted work on the eFrailty Tool and outlined the impact that frailty has in Scotland and the number of people affected by this. Just over 10% of the population of Scotland are affected by frailty. The tool will be developed to identify people at risk and implement evidence based interventions.

Dr Armstrong went on to note a number of areas of work including community led care for people with coeliac disease; a range of alternative options for conducting outpatient appointments such as virtual consultations; development of Diabetes Local Care with the development of an app to provide lifestyle coaching and promote self-management and self-care. Extensive work has been undertaken to engage with the community, patients, staff and HSCP's.

Mr Brown thanked Dr Armstrong for the update and was pleased to note the development of new pathways and engagement with staff, members of the public and the 3rd sector. He invited comments and questions from Board members.

In response to comments from Board members in respect of the work streams being developed and the potential financial implications, recognising the potential to utilise the 1% flexibility of the 3 year financial cycle, Dr Armstrong agreed to develop a summary of all of the work streams being progressed and would present this to a future Board meeting. Mr White added that, once work streams had been financially assessed, this would be presented to the Board in due course. Ms Grant highlighted that caution would need to be exercised in considering use of the 1%, in the context of financial balance over 3 years and key challenges. Ms Grant assured members that individual cases of change would include financial detail, however this was an incremental process towards developing a clear picture of the financial benefits of the Moving Forward Together Programme.

Medical Director

Questions were raised in relation to the frailty programme of work and the inclusion of prevention. Dr McGuire assured members that the tool would predict those who were at risk of becoming frail, with preventative measures applied.

Board members queried learning from other Board areas, and noted the recent Quality Improvement work which had been progressed in NHS Fife. Dr McGuire advised Board members that work undertaken in NHS Fife was in relation to emergency care therefore was different to the work described here. However Dr McGuire assured members that the programme of work, similar to that in NHS Fife, had been rolled out in NHSGGC.

In response to a request from Board members regarding additional time to fully discuss and explore the wider picture for Moving Forward Together, Ms Grant agreed that a presentation of the strategic critical path would be developed to bring together all of the areas being progressed. This would be considered by the Finance and Planning Committee, before being presented to the Board. Board Seminars would also be utilised to provide Board members with an overview of the work as this develops.

In summary, the Board were content to note the progress made in the implementation phase of the programme, and thanked Dr Armstrong and colleagues for their efforts to develop this.

NOTED

38. NHSGGC DIGITAL DELIVERY PLAN

The Board considered the paper 'NHSGGC Digital Delivery Plan' [Paper No. 19/16] presented by the Director of eHealth, Mr Williams Edwards. The Board were asked to note progress since approval of the 'Digital Strategy 2018-2022 Digital As Usual' in August 2018. Mr Edwards highlighted the synergy of the Plan with the Moving Forward Together Programme. Mr Edwards described the 5 key areas set out in the Strategy including Integrated Electronic Health & Care Records; Self Care & Remote Care; Informatics & Data Analytics; Workforce & Business systems; and Technology Infrastructure. Following approval of the Strategy by the Board, extensive stakeholder engagement was undertaken to develop a comprehensive three year plan. 10 major programmes of work had been identified, those being:

- Integrated Electronic Health & Care Record (IEHCR)
- Primary Care & Contractor Services;
- Safer Medicines;
- Innovations;
- Patient Admin Transformation;
- Safer Diagnostics;
- Clinical Informatics;
- Technology & Infrastructure;
- Self Carer & Remote Care;

- Workforce & Business Systems

Mr Edwards provided an update on progress of each of the programme deliverables in 2018/19, including areas such as widening access to West of Scotland Health Boards in relation to the IEHCR; the implementation of the medicines reconciliation and immediate discharge letter; digital ordering of radiology tests which supports the ambitions of the Moving Forward Together Programme; establishment of a team to consider ways in which patients are communicated with; implementation of advice referrals to enable GPs to seek advice from specialist clinicians to determine best course of action; innovation projects such as the management of COPD (Chronic Obstructive Pulmonary Disease) at home; and development of the Industrial Centre for Artificial Intelligence Research in Digital Diagnostics (ICAIRD). Mr Edwards also noted significant development in relation to the implementation of eESS (Electronic Employee Support System), and capital funding secured to commence a rolling programme of user device replacement.

A number of programme deliverables for 2019/20 – 2020/21 were highlighted including the further development of the IEHCR; development of digital Anticipatory Care Plans; and completion of the electronic prescribing programme. Mr Edwards noted that the full business case in relation to electronic prescribing would be presented to the Board in due course. Mr Edwards noted the identification of £3.7m funding to pump prime some of the programmes described and focus remained on identifying opportunities to increase capital funding from other sources. Mr Edwards also described the governance process in place and advised the Board that each Moving Forward Together work stream included representation from an e-Health Clinical Lead and a senior member of the e-Health Strategy and Programmes Team.

Director of eHealth

Mr Brown thanked Mr Edwards for the update and noted the paper described new ways of working and was pleased to note the strong links with the Moving Forward Together Programme. Mr Brown invited comments and questions from Board members.

In response to questions raised regarding understanding and awareness of staff in relation to the developments, specifically the quality of data, Mr Edwards assured the Board that each of the initiatives described have a Programme Board established which included representation from stakeholders with a number of Clinical Leads representing areas across the organisation.

Board members were pleased to note the progress of the Digital Implementation Plan and noted the complexity of the work, as a whole, and also within primary care. Members felt there was a significant need to support the transformation of systems to improve access to information for a number of key professionals. Improving staff and professionals knowledge and understanding of the developments within the digital field was crucial to its success, therefore it was critical that training needs and support were considered. Dr Armstrong was clear that ehealth leads and clinical leads were instrumental in both changing the culture of the organisation and supporting staff to embrace new ways of working.

A question was raised in respect of the ambitions for the replacement PACS radiology system, and Mr Edwards noted the incremental nature of this work due to a number of factors including the requirement for increased development across all Boards in respect of the IEHCR. NHSGGC remained committed to ensuring a wide range of professions were able to access the IEHCR, to maximise the benefits for patients.

In summary, the Board were content to note the progress made and agreed that updates would be presented to Corporate Management Team and the Finance & Planning Committee, on a regular basis, with a summary to the Board.

NOTED

39. NHSGGC INITIAL DRAFT ANNUAL OPERATIONAL PLAN

The Board considered a paper 'NHSGGC Initial Draft Annual Operational Plan' [Paper No. 19/17], presented by the Director of Finance, Mr Mark White. The paper described the Scottish Government requirement for the preparation and submission of an Annual Operational Plan (AOP); the Board's current position and process for drafting; and an overview of the presentation and discussion at the recent Finance and Planning Committee meeting of 2nd April 2019.

The Scottish Government guidance described the key areas of focus, those being; Waiting Times for Elective, Cancer and Unscheduled Care; Integration; Mental Health; Primary Care; Healthcare Associated Infection and Finance. Collaboration with HSCP and 3rd sector colleagues continued to ensure that the AOP accurately reflects the areas of development.

Mr White further noted that clarity was sought from Scottish Government colleagues in relation to the amount and timing of funding prior to finalising the plan in respect of access targets and action. Mr White was confident that these discussions would be concluded in early May 2019.

Mr Brown thanked Mr White for the update.

In summary, the Board were content to note the Initial Draft Annual Operational Plan, with the expectation that further discussion would take place at the Board Seminar meeting in May 2019. The final Plan would be presented for endorsement to Finance and Planning Committee in June, with final approval at the Board Meeting in June 2019.

Director of Finance

NOTED

40. ACUTE SERVICES COMMITTEE UPDATE

The Board noted the draft minutes of the Acute Services Committee [ASC (M) 19/02] which took place on 19th March 2019.

Mr Finnie, Chair of the Acute Services Committee, provided an overview of the key areas of discussion, including the Integrated Performance Report. The Acute Services Committee agreed that there was a large amount of information contained within the report and acknowledged that there was a need to redesign the report to improve clarity. Ms Vanhegan, Head of Corporate Governance and Administration, has reflected on ways in which reporting could be improved across Committee structures to reduce duplication where possible, as part of the review of Committee Terms of Reference.

The Committee also discussed a number of areas such as the progress made in relation to the Waiting Times Improvement Plan; review of Cowlairs Decontamination Unit; and a comprehensive report on Delayed Discharge across Acute hospital sites was presented. Performance has improved over the last two years, however focus was required to improve and sustain this in Delayed Discharges. The Committee also sought assurances regarding the creation of additional Executive Team capacity and were pleased to note the actions being undertaken to address this.

Mr Brown thanked Mr Finnie for the update and the Board were content to note the draft minute.

NOTED

41. NHSGG&C INTEGRATED PERFORMANCE REPORT

The Board considered the paper 'NHSGG&C Integrated Performance Report' [Paper No. 19/18] presented by Mr Mark White, Director of Finance.

Mr White noted that the report format remained in a transitional layout as work continued to review and redevelop this.

Mr White highlighted the areas meeting or exceeding target including access to a range of services including Drug and Alcohol Treatment; Alcohol Brief Interventions; Smoking Cessation; Psychological Therapies; and IVF Treatment. Mr White also noted progress made in respect of compliance with Stage 1 Complaint response and outpatient appointments.

Mr Best went on to highlight the areas which remain challenging, including the cancer 62 day target; the treatment time guarantee; emergency department and assessment unit attendances; and Child and Adolescent Mental Health Service. Mr Best described some of the actions being undertaken to address these including the recruitment of a Waiting Times Service Manager; the appointment of a 6 month locum

Consultant Radiographer; and a new physiotherapy concept being trialled within the Emergency Department, which had already received positive feedback.

Mr Best paused for questions from Board members.

Mr Brown welcomed the changes made to the presentation of the report and was encouraged by the positive improvements made.

In response to questions from Board members in relation to the reported increases in demand and the cause of this, Mr Best advised that work had been undertaken to implement a Redirection Policy to address inappropriate attendances to Emergency Departments. Dr de Caestecker advised that activity appears to represent a growing number of older patients from more affluent areas attending at Emergency Departments, which corresponded with a reduction in use of Out of Hours Services. Dr de Caestecker agreed to provide Board members with further information on this in the next report.

Director of Public Health

The Board questioned if the activity reports were shared with Integration Joint Boards, and Ms Long clarified that Inverclyde IJB has a performance dashboard which details all of the MSG targets and this is reviewed regularly to ensure that the actions being taken were having the desired impact. Therefore, the IJBs do discharge their responsibilities for ensuring that actions were being taken to address performance issues.

It was highlighted that it would be useful to explore the reasons for increase in demand with patients, and Dr de Caestecker was in agreement. Ms Long noted that work had been undertaken in Inverclyde and East Renfrewshire in relation to this.

The Board were pleased to note the performance of the Minor Injury Units at both Victoria and Stobhill Hospitals, and suggested exploration of this to determine best practice and learning.

Dr McGuire went on to provide an overview of the actions underway to address performance of the Child and Adolescent Mental Health Service. The Team have been considering different ways of working through the implementation of a quality improvement programme. This included investigation of the numbers of referrals requiring redirection; investigation of the increase in demand; and a focus on reduction of 'did not attend' occurrence. Dr McGuire was confident that the solid foundations being put in place would improve performance, however acknowledged that there was further work to be done.

Dr McGuire went on to describe the actions being taken to address delayed discharge performance and noted that a detailed paper had recently been presented to the Acute Services Committee. Focus remained on working with partners and Health and Social Care Partnership colleagues, to identify and address the challenges, to

Chief Operating Officer

prevent patients from requiring admission to hospital.

Mr Brown thanked Dr McGuire for the update. There were no questions noted.

Mrs MacPherson provided an overview of the sickness absence performance within NHSGGC, and noted a spike in absence in January 2019 which had subsequently been reduced. There was a reduction in the occurrence of long term absences. Mrs MacPherson assured Board members that focused work continued with the specific Divisions that required improvement. There were some emerging pieces of work identified including a focus on long term conditions; the Human Resource Team supporting managers to improve support to staff; and a campaign with the Communications Team to promote self help for staff. A report on the progress of the areas identified by the external Audit report findings would be presented to the Acute Services Committee.

Director of Human Resource and Organisational Development

Mr Brown thanked Mrs MacPherson for the update and was assured that the Staff Governance Committee take a detailed assessment of this.

The Board were content to note the update.

NOTED

42. ADULT AND OLDER PEOPLE MENTAL HEALTH DELAYED DISCHARGES

The Board considered the paper 'Adult and Older People Mental Health Delayed Discharges' [Paper No. 19/19] presented by the Chief Officer of Glasgow City HSCP, Mr David Williams. The paper provided an update on the current position and the actions taken to improve performance and outcomes for patients, following the report presented to the Board in 2018. Mr Williams provided an overview of adult mental health performance; learning disability performance and older people performance. The report also detailed three case studies which demonstrated the complex needs of these patient groups and assured the Board that focus remained to ensure robust arrangements were in place to support individuals.

Mr Brown thanked Mr Williams for the update and invited questions from Board members.

In response to queries from Board members with regards to oversight of complex cases with specialist needs, Mr Williams clarified that Ms Julie Murray, Chief Officer East Renfrewshire HSCP, maintains oversight and has regular dialogue with Chief Officer colleagues to ensure that individuals with complex needs are supported.

The Board were content to note the update and would expect a further update in due course.

Chief Officer, Glasgow City HSCP

NOTED

43. CLINICAL AND CARE GOVERNANCE COMMITTEE UPDATE

The Board considered the draft minute of the Clinical and Care Governance Committee Meeting of 5th March 2019, [CCG (M) 19/01]. Ms Brimelow, Chair of the Committee, provided an overview of the topics discussed including detailed scrutiny of the issues and assurance sought regarding hand hygiene audits.

NOTED

44. HEALTHCARE ASSOCIATED INFECTION REPORT

The Board considered the paper 'Healthcare Associated Infection Report' [Paper 19/20] presented by Dr Jennifer Armstrong, Medical Director.

The report highlighted a total of 104 validated cases of Staphylococcus aureus Bacteraemia (SAB) reported from October 2018 to December 2018. This was above the national average. Reduction of SABs remained a priority and the SAB Group continued to meet regularly and implement actions based on emerging evidence and quality improvement initiatives.

The report provided an update on the water and ventilation system at QEUH and RHC, and Dr Armstrong noted that installation of a continuous (low level) chlorine dioxide water treatment system was now complete and there had been no cases of bacteraemia associated with water since September 2018.

Dr Armstrong went on to note that over 800 air samples had been taken in relation to Cryptococcus neoformans, however Cryptococcus had not been identified in air sampling since the end of January 2019. Air sampling continued and no incidence of infections had been identified since December 2018.

Dr Armstrong described a number of actions being undertaken in respect of the 13 cases of an unusual strain of Staphylococcus aureus Bacteraemia at Princess Royal Maternity Hospital (PRM); Royal Hospital for Children (RHC); and Royal Alexandra Hospital (RAH), in very ill, extremely premature babies. Dr Armstrong noted a number of actions being taken including enhanced cleaning of all three units which included a hydrogen peroxide vapour clean in PRM, microbiological swabbing of the environment; hand hygiene audits; enhanced supervision; and screening of staff and babies.

Dr Armstrong also noted the identification of 4 patients with Group A Streptococcus (GAS) at Stobhill Hospital which were subsequently confirmed to be different types and therefore not due to cross infection, and also a recent increase in confirmed cases of Norovirus.

Dr McGuire went on to provide an update on the issues and actions to address these following the Healthcare Environment Inspectorate (HEI) unannounced inspection of Royal Alexandra Hospital in December of 2018.

Dr McGuire also provided an overview of the actions to address issues identified following the HEI unannounced inspection of the QEUH Campus between 28th January and 3rd February 2019.

Dr Armstrong described the actions underway in relation to Surgical Site Infection (SSI) Surveillance and was pleased to note a reduction in the number of hip arthroplasty SSI's this quarter.

Mr Brown thanked Dr Armstrong and Dr McGuire for the update and was pleased to note improvements made. Mr Brown noted that there had been no water related infections for the past 7 months and no Cryptococcus infections in the past 4 months.

Mr Brown invited questions from Board members.

In response to questions from Board members in relation to the publication of Cryptococcus data from sampling, Dr Armstrong advised that this was being reviewed and would be presented to the Board in the near future, once analysis of the data was complete. **Medical Director**

Following questions regarding the screening of staff at PRM, Dr Armstrong highlighted that this included bank staff.

In response to questions from Board members in respect of the cleaning compliance report for QEUH, in comparison to other hospital sites, Mr Steele, Director of Estates and Facilities, confirmed that the cleaning model used at QEUH Campus was different to that used at other sites. Following the Healthcare Improvement Scotland (HIS) inspection, Mr Steele requested an external review of the model and was awaiting feedback on this. Mr Steele assured the Board that should the audit confirm that the model was less effective as other models, plans would be put in place to change the model. Mr Brown requested that Mr Steele provide a report to the Clinical & Care Governance Committee on the outcome of the audit and the effectiveness of the model, once available. **Director of Estates and Facilities**

The Board were content to note the report and were assured that actions were in place to improve performance.

NOTED

45. AREA CLINICAL FORUM

The Board considered the approved minute of the Area Clinical Forum Meeting of 7th February 2019 [ACF (M) 19/01].

Mrs Thompson, Chair of the Area Clinical Forum, provided an overview of the topics discussed. She noted that the Forum have co-opted a representative from Infection Control, identified by the Area Nursing and Midwifery Committee, to provide specialist advice and information to the Forum on infection prevention and control issues. The Forum were keen to take a proactive approach and as such, have considered the Corporate Objectives and agreed to discuss these within their respective advisory Committees to identify key areas for scrutiny.

Mr Brown thanked Mrs Thompson for the update.

The Board were content to note the minutes.

NOTED

46. NHSGG&C GOVERNANCE AND ASSURANCE MECHANISMS

The Board considered a paper 'NHSGG&C Governance and Assurance Mechanisms' [Paper No. 19/21] presented by the Medical Director, Dr Jennifer Armstrong.

Following events in 2018 in another NHS Scotland Health Board area which generated public concern over surgical safety, a national assurance exercise was undertaken and the Cabinet Secretary wrote to every NHS Board seeking confirmation of internal arrangements that ensure prevention, recognition and response to concerns of clinical quality in surgical settings. NHSGG&C were highly commended at the national meeting on 4th December 2018 and it was noted that the organisation had the highest national appraisal rate in Scotland at 94%. Positive feedback was received from the Scottish Government, who were assured that NHSGG&C had robust processes in place regarding unexpected outcomes and patient safety programmes. Dr Armstrong assured Board members that although the feedback received was positive, focus remained to ensure continuous improvement.

Mr Brown thanked Dr Armstrong and was pleased to note the efforts of colleagues in achieving high standards. Mr Brown invited questions from Board members.

In response to questions from members in relation to cancellation of elective surgery to allow quarterly joint meetings, Dr Armstrong expanded on this and clarified that elective sessions were not scheduled, as opposed to cancelled.

NOTED

47. STAFF GOVERNANCE COMMITTEE UPDATE

Mr Alan Cowan, Chair of the Staff Governance Committee, advised that the next meeting of the Committee would take place on 7th May 2019.

Mr Cowan noted that an informal meeting of key Committee members took place to review the extract of the Corporate Risk Register. Mr Cowan also noted that reports on Organisational Culture and the Staff Governance Monitoring Framework would be presented at the next Committee meeting in May 2019.

Mr Brown thanked Mr Cowan for the update.

NOTED

48. WIDENING ACCESS TO EMPLOYMENT

The Board considered the paper 'Widening Access to Employment' [Paper No. 19/24] presented by the Director of Human Resources and Organisational Development, Mrs Anne MacPherson. The report detailed the activity undertaken to support the Widening Access to Employment agenda for the period 2018-2019. Mrs MacPherson described a number of activities that NHSGGC were involved in including Careers Awareness events; the Careers Insight Programme; Pre-Employment Training; Project Search; and Modern, Foundation and Graduate Apprenticeships.

Mr Brown thanked Mrs MacPherson for the update and was pleased to note the large range of activities being undertaken in NHSGGC. Mr Brown wished to note thanks on behalf of the Board to Mrs MacPherson, her team and all of the individuals supporting this programme. Mr Brown invited questions from Board members.

Board members felt it would be useful to include data from a national perspective to gain a better understanding of NHSGGC performance in the context of national performance. Mrs MacPherson highlighted that NHSGGC was the Champion Board in Scotland and had twice won the Employer of the Year Award. Mrs MacPherson advised that she would ask that benchmarking figures for Scotland be obtained and included in the report.

Director of Human Resource and Organisational Development

Following comments from Board members in relation to equalities impact assessments, Mrs MacPherson agreed to include data on the number of disabled people accessing opportunities in the next report.

NOTED

49. HEALTH AND SOCIAL CARE STAFF EXPERIENCE REPORT

The Board considered the paper 'NHS Scotland Health and Social Care Staff Experience Report' [Paper No.19/25] presented by the Director of Human Resources and Organisational Development, Mrs Anne MacPherson. The report detailed the summary outcomes for staff experience in NHSGG&C in 2018, the actions of which were discussed and monitored through the Staff Governance Committee Action Plan.

Mrs MacPherson described the key elements of the report including

questions about duties and responsibilities; performance management; involvement in decisions and visibility of managers. Mrs MacPherson noted that it was crucial that teams discuss their individual team reports and develop action plans based on this, therefore focus remained on encouraging all staff to participate in this to achieve the baseline response of 60% to achieve an overall Board report.

Mr Brown thanked Mrs MacPherson for the update and invited questions from Board members.

In response to questions from members in relation to the 60% minimum response rate, Mrs MacPherson advised that this had been raised nationally and that a review of the system was currently underway. Mrs MacPherson provided further clarity on the role of team leads within this process, and assured members that a number of activities had been undertaken to improve response rates including briefing sessions and the development of champions.

The Board were content to note the report.

NOTED

50. FINANCE AND PLANNING COMMITTEE UPDATE

The Board considered the draft minute of the Finance and planning Committee Meeting [FP (M) 19/02] of 2nd April 2019. Mr Brown highlighted the key areas of discussion including a detailed review of the Revenue Report; the Financial Improvement Programme; the Capital Plan; and the Financial Forecast for 2019/20. Mr Brown also noted that the Committee discussed and agreed the direction of travel of the GP Out of Hours Service Review and asked for assurance regarding engagement and equality impact assessments and capacity within NHS24 prior to any implementation of changes or alteration to access routes. Ms Grant had also provided an update on QEUH and RHC, and Dr Armstrong provided an update on the Moving Forward Together Programme. The Committee reviewed an evaluation of the Small Change Matters programme and were pleased to note the success of this and the positive changes made.

The Board were content to note the draft minutes.

NOTED

51. AUDIT AND RISK COMMITTEE UPDATE

The Board noted the draft minutes of the Audit and Risk Committee meeting of 12th March 2019 [AR (M) 19/02]. Mr Allan McLeod, Chair of the Audit and Risk Committee, provided an overview of the topics discussed including reports presented by the Internal Auditors regarding the Audit Plan; an update on the Audit Scotland preliminary work in preparation for close of final accounts for 2018/19; and an assessment of the Financial Improvement Programme, which was found to be a well

developed programme with high levels of scrutiny.

Mr Brown thanked Mr McLeod for the update and wished to note thanks on behalf of the Board to the members of the Audit and Risk Committee for their efforts. Mr Brown was pleased to note the positive assessment of the Financial Improvement Programme and was confident that this would continue to develop. Mr Brown invited questions from Board members.

In response to questions from Board members in relation to opportunities for the Board to feed into the Audit Plan, Mr McLeod advised that the Board would have the opportunity to contribute to the Plan, however the Plan would be subject to approval by Corporate Management Team and the Audit and Risk Committee, before presentation to the Board. However, Mr McLeod was happy to discuss any individual Committee concerns should Committee Chairs wish to do so. Mr Brown assured Board members that the risk management process and systems would be considered as work develops to review corporate governance.

Following questions from Board members in respect of the Executive Team capacity, Ms Grant advised that a paper was presented and approved by the Remuneration Committee which detailed additional support to Acute Division senior management, with the addition of the Acute Chief of Medicine post and an Acute Chief of Nursing post, to support the Chief Operating Officer. In addition, an Assistant Director of Planning had been appointed and would take up post in May 2019. Ms Grant also noted that work was underway to appoint to the Acute Medical Director post and Mr Alan Hunter had recently taken up the position as Director of Access. Ms Grant was confident that there was significant additional senior management capacity created.

Discussion took place regarding governance reporting structures and it was highlighted that the Remuneration Committee reports to the Staff Governance Committee. Mr Brown suggested that it would be helpful for the Board to receive a briefing following Remuneration Committee meetings to ensure that the Board were informed of developments.

Head of Corporate Governance and Administration

NOTED

52. NHSGGC REVENUE AND CAPITAL REPORT

The Board considered the paper 'NHSGGC Month 11 Revenue and Capital Report [Paper No. 19/22] presented by the Director of Finance, Mr Mark White.

Mr White reported that as at 28th February 2019, the Board reported expenditure levels of £2.5m over budget. This compared to £10.2m over spent at the previous month end and was significantly better than the initial trajectory forecast of £47.7m.
The Financial Improvement Programme tracker recorded projects

totalling £56.4m on a FYE and £40.3m on a CYE. Taking into account the need for contingency to cover cost pressures within Acute Division and the use of non-recurrent funds to support the in-year financial challenge, the Board was predicting a break-even position for 2018/19.

Mr White highlighted significant overspends within Acute and Corporate Divisions due to unachieved savings, and noted that £50.8m of non-recurring relief had been factored in to support the financial position. Mr White advised that Partnerships reported an under spend of £3.6m, however noted that as prescribing data remained 2 months behind in reporting, prescribing costs could have an impact on the current figure reported.

Mr White described the Financial improvement Programme position breakdown and noted that a number of programmes would roll forward to 2019/20.

Mr White highlighted cost pressures for 2018/19 including the water issue at the QEUH which had created a projected revenue cost of £1.5m; the fire at Stobhill Hospital which would require £1.5m of demolition costs; and additional allocation of up to £4m from the revised Financial Plan to support winter costs.

The capital resource limit for 2018/19 was achieved and Mr White highlighted the areas progressed including ward refurbishments at Glasgow Royal Infirmary (GRI); buildings infrastructure upgrade schemes at the Institute of Neurosciences (INS) and the Neurology Building; the upgrade and redevelopment of the Intensive Care Unit (ICU) at RAH; the medical equipment replacement programme and the investment in e-health.

Mr Brown thanked Mr White for the update and was pleased to note the positive financial position. Mr Brown invited questions from Board members.

In response to questions from members regarding the under spend within Partnerships, Mr White assured Board members that activities to ensure the best use of collective resource to manage performance was underway and Mr White was confident that positive steps had been taken to improve balance and ensure greater focus on performance targets.

Following questions from members in respect of the paid-as-if-at-work claims, Mrs MacPherson clarified that this was an accrual made, following the recent case in NHS England regarding Agenda for Change (AFC) bands and overtime payments. National negotiations were underway in relation to this. This will affect all employers.

Board members acknowledged the significant effort to achieve a break-even position and were pleased to note a steadily improving financial position.

Discussion took place regarding the approval process associated with the conversion of capital under spend to non-recurring revenue to support the overall financial position. Mr White clarified that this was approved as part of the Capital Plan report which summarised the intention to do so. Mr Brown further noted that this had been approved by the Finance and Planning Committee as part of the Capital Plan. Once approved by Scottish Government, this then required to be endorsed by the Board.

The Board were content to note the position at Month 11, were content to endorse the transfer of £10m capital to revenue; and noted the Financial Improvement Programme position.

NOTED

53. NHSGGC INITIAL DRAFT FINANCIAL PLAN 2019/20

The Board considered the paper 'NHSGGC Initial Draft Financial Plan 2019/20' [Paper No. 19/23] presented by the Director of Finance, Mr Mark White. The report provided the Board with an update of the 2019/20 projected revenue and capital positions, and outlined the planning process to deliver key financial targets. Mr White reported that the Board were projecting a reduction in underlying recurring deficit by £19.5m to £48.3m in 2018/19, however this was subject to finalisation of Month 12 and the annual audit process. Mr White noted that Territorial Boards would receive an uplift of 2.54%, which includes funding for the 2019/20 pay award.

The report highlighted the cost inflation, pressures and developments including recurring costs of the band 2 to band 3 re-grade; increasing number of patients receiving TAVI (Transcatheter Aortic Valve Implantation); IT contracts and increasing energy costs.

Mr White went on to note that Health and Social Care Partnership (HSCP) budgets required to be determined by 31st March 2019. Mr White noted that details of proposed delegated budgets were submitted to the last cycle of Integration Joint Board meetings. The Board were content to approve the financial delegation to HSCP's as described within the paper. However, there were further questions in respect of the total funding for HSCP's from the Health Board and the Local Authorities. Mr White advised that this had been debated at the Finance and Planning Committee; however this was a very complex topic which required further consideration before presenting to the Board. It was agreed that Mr White would discuss HSCP financial settlements with Board members at a future Board Development Session.

Director of Finance

Mr Brown advised members that HSCP funding would be included within the Board development programme and that a session would be arranged to progress the MSG Review outcomes, to clarify roles and responsibilities of IJB members and support to NHS members of IJBs.

The Board discussed the 3 year planning cycle and Mr White clarified that a deficit of 1% was now permitted to be recorded, provided a clear plan was in place to balance this in a later financial year within the 3 year period.

Mr Brown thanked Mr White for the update and invited questions from Board members.

In response to questions from Board members in respect of the miscellaneous cost pressures detailed within the report, Mr White advised that this was included to ensure greater visibility and prudence, however Mr White noted that this would be updated as the financial year progressed.

Mr White reported that the Capital Plan for 2019/20 would include a number of works including those identified at QEUH for ventilation and a pedestrian walkway. The outcome of the national review of forensic mental health services was awaited and would shape the direction of the Rowanbank scheme. £6.65m of capital funding had been allocated to support e-health priorities, £5m had been allocated to the medical equipment replacement programme and £9.25m allocated to minor maintenance works. There was £3.1m of capital unallocated to ensure contingency within the plan.

In response to questions from Board members in respect of the devolved budget to IJBs and accountability, Mr Brown assured Board members that both the Board and the Local Authorities receive reports from HSCPs that holds IJBs to account for delegated budgets. The MSG Review of Progress of Integration, had highlighted some issues with regards to the flow of information and, this, along with the national Blueprint for Good Governance, were expected to address these issues both locally and nationally.

In summary, the Board were content to note the latest assessment of the financial position for 2019/20; the latest assessment of the 3 year revenue overview; the high level Financial Plan (Initial Draft); approve the draft Capital Plan; and approve the proposition for the 2019/20 HSCP delegated budget allocation.

APPROVED

54. CORPORATE GOVERNANCE IN NHSGG&C

The Board considered the paper 'Corporate Governance in NHSGG&C' [Paper No. 19/26] presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The paper summarised the recent development session which considered the Board's position in respect of the NHS Scotland Blueprint for Good Governance. The Board were required to submit a report to the Scottish Government by the end of April 2019, which would be based on the paper presented to the Board

and the Action Plan appended. The Board were asked to approve the Action Plan for submission to the Scottish Government. Ms Vanhegan advised the Board that she intended to provide a progress update to the Board in October 2019. The Annual Review of the Scheme of Delegation would be presented to the June Board meeting as part of the routine review of governance.

Mr Brown thanked Ms Vanhegan for the update and invited questions from Board members.

Following comments from Board members regarding Corporate Management Team capacity, given the ambitious timescales, Ms Vanhegan agreed to further consider the sequencing of the planned work.

In response to observations from Board members in respect of the inclusion of the public health priorities, it was agreed that public health would be highlighted more explicitly within strategic plans.

In response to questions from Board members regarding influencing culture and development of a common understanding, it was agreed that time would be allocated to the Board Seminar schedule to discuss the matter further.

In summary, the Board were content to approve the Action Plan, subject to amendments to describe further the public health agenda and influencing culture. Consideration to the timescales and sequencing of work was also required.

Head of Corporate Governance and Administration

APPROVED

55. BOARD MEMBERSHIP AND REVIEW OF GOVERNANCE COMMITTEE AND INTEGRATION JOINT BOARD MEMBERSHIP

The Board considered the paper 'Board Membership and Review of Governance Committee and Integration Joint Board Membership [Paper No. 19/27] presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The report detailed the recent changes to Committee membership and IJB membership following the appointment of Ms Margaret Kerr, Ms Flavia Tudoreanu and Ms Amina Khan.

Mr Brown thanked Ms Vanhegan for the update and for her efforts to balance representation on the Committees. Mr Brown welcomed discussion with any Board members interested in becoming a member of any of the Committees.

Discussion took place regarding the Staff Governance Committee, which required a greater number of non-Executive Board members present to satisfy quorum. Ms Vanhegan assured Board members that she was undertaking work to align all of the Committees in this respect as part of

the Annual Review of Governance.

NOTED

56. PHARMACY PRACTICES COMMITTEE UPDATE

The Board considered the draft minute of the Pharmacy Practices Committee Meeting of [PPC (M) 2019/01] of 11th February 2019.

NOTED

57. VALEDICTORY

Mr Brown noted that this was Mr Ally McLaws final Board Meeting as Director of Communications. Mr Brown wished to note his thanks and best wishes to Mr McLaws on behalf of the Board, for his efforts and contributions to the organisation. A formal farewell presentation would take place on 2nd May and Board members were invited to attend.

58. DATE AND TIME OF THE NEXT MEETING

Tuesday 25TH June 2019, The William Quarrier Centre, St Kenneth Drive, Govan, G51 4QD.

The meeting concluded at 4.05pm

NHS Greater Glasgow & Clyde	
Meeting:	**NHS Board - Paper No. 19/38**
Date of Meeting:	**25th June 2019**
Purpose of Paper:	**Approval.**
Classification:	**Board Official**
Sponsoring Director:	**Elaine Vanhegan** **Head of Corporate Governance and Administration**

Title

Governance Framework Review - Phase 1 2019

Recommendations:-

The NHS Board is asked to:

- Note the first phase of work undertaken to review the governance framework across the NHS Greater Glasgow and Clyde (NHS GGC) ahead of the publication of further national guidance in respect of the Blueprint for Good Governance and any further actions arising from the recent Ministerial Strategic Group's report on increasing the pace of the Integration of Health and Social Care.
- Approve the key elements of the governance framework as noted below.
- Note that any further requirements from the national review of governance will be considered and updates taken to the Audit and Risk Committee and onward to the NHS Board by the end of the calendar year.

Purpose of Paper:-

To approve the combined governance framework which includes:

- The Code of Conduct for members of NHS Greater Glasgow and Clyde.
- The NHS Board Standing Orders, including Decisions Reserved for the NHS Board.
- The Standing Financial Instructions.
- The Scheme of Delegation drawn from the Standing Financial Instructions and other Board requirements in respect of specific roles and functions e.g.

Clinical and staff Governance, noting the appended draft schemata clarifying roles of governance, management and operations acknowledging the role of the Corporate Management Team (CMT). This will be developed further over the coming months with further CMT discussion planned.

- The Standing Committee Terms of Reference, noting that the Public Health Committee Terms of Reference will be considered by the committee at the scheduled meeting on the 24th July.
- Templates for use by all Standing Committees of the Board including Agendas, Minutes, Rolling Action Logs, Papers for submission, Committee Annual Reports and Committee Chairs reporting template.

Key Issues to be Considered:-

Context

Board members will be aware that a national process is underway through the NHS Scotland Corporate Governance Steering Group to implement NHS Scotland's 'A Blueprint for Good Governance'. The NHS Board were advised at their meeting in February 2019 of the content of the Blueprint and of the Scottish Government's commitment to implementing the Blueprint as set out in DL(2019)02. Nationally-led work will, in due course, result in the introduction of nationally consistent, NHS Board Standing Orders, Schemes of Delegation and Terms of Reference for all mandatory committees. Mandatory committees are described as; Staff Governance Committees, Audit and Risk Committees and Clinical and Care Governance Committees

Board members will also be aware that the Ministerial Strategic Group (MSG) Review of the Progress of Integration with Health and Social Care, was published in February 2019, setting out proposals designed to underpin and drive forward integration.

The first phase of the work undertaken to review the governance framework across the NHS GGC is presented to the Board, acknowledging the national work described above and recognising further amendments will be required later in the year. The proposed amendments take account of the national direction in ensuring that the Board's corporate governance framework suitably applies a 'whole system' approach to oversight of the Board's functions.

Phase 2 will be considered once the national work reports into the autumn of this year.

The following are key issues for noting and consideration:

Code of Conduct

The Code of Conduct of Members of NHS Greater Glasgow and Clyde Board - remains unchanged from 2018.

Standing Orders

NHS Board Standing Orders have been updated removing the use of *He/She* to *They* or *Their;* in line with Equality and Diversity guidelines and also noting department and individuals' title changes.

Standing Financial Instructions

Minor changes were approved by the Audit and Risk Committee on June 4th 2019.

Scheme of Delegation – including Matters reserved for the NHS Board

Matters reserved for the NHS Board have been updated:

- Replacing the Local Delivery Plan (LDP) with the Annual Operational Plan (AOP), inclusion of Corporate Objectives and Values of Organisation and;
- Stating that the Scheme of Delegation is part of the overall governance framework.

In terms of the Scheme of Delegation key changes relate to:

- The inclusion of a Staff Governance Section
- The inclusion of a Public Health Section
- Confirmation of delegation in respect of Information Governance
- Confirmation of the role of standing governance committees in respect of Risk Management
- The inclusion of responsibilities in respect of Equality Legislation
- Changes in title of the Finance and Planning Committee to the Finance, Planning and Performance Committee

Committee Terms of Reference

All Standing Committee Terms of Reference are formatted in the same template ensuring consistency, and now include additional core responsibilities as detailed below;

- Ensuring appropriate governance in respect of risks, as allocated by the Audit and Risk Committee, to respective standing committees, ensuring that committees are reviewing risk identification, assessment and mitigation, in line with the NHS Board's risk appetite, and agreeing appropriate escalation.
- Participation in an annual review of standing committee's remit, membership and attendance to be submitted to the NHS Board in June of each year with a template for completion noted in the template section of the governance framework.

Standard Templates

A suite of standard templates have been created for Agendas, Minutes and Rolling Action Logs (RALs) and committee papers to ensure consistency across the Board

and standing committees. In terms of rolling actions, if an action is noted to be on a Forward Planner, the action can be closed if the date is noted to be on the relevant committee Forward Planner and on the respective RAL. The Corporate Services Team will be responsible for maintaining Forward Planners for the NHS Board and standing committees, and Board members can review relevant Forward Planners at any time.

To ensure adherence to equality requirements, all papers should be submitted in Ariel font size 12.

A template has also been created for committee Chairs to use to ensure a consistent approach to standing committee feedback to the NHS Board. The Corporate Services Team will support committee Chairs in completing the template in readiness for the next NHS Board meeting.

Any Patient Safety/Patient Experience Issues

None

Any Financial Implications from this Paper

None

Any Staffing Implications from this Paper

None

Any Equality Implications from this Paper

None

Any Health Inequalities Implications from this Paper

None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.?

No

Author – Elaine Vanhegan

Tel No – [redacted]

Date –13/06/19

NHS Greater Glasgow and Clyde Annual Review of Governance 2019

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CODE of CONDUCT

for

MEMBERS

of

NHS GREATER GLASGOW & CLYDE

CODE OF CONDUCT for MEMBERS of NHS GREATER GLASGOW & CLYDE

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SECTION 1: INTRODUCTION TO THE CODE OF CONDUCT

1.1 The Scottish public has a high expectation of those who serve on the boards of public bodies and the way in which they should conduct themselves in undertaking their duties. You must meet those expectations by ensuring that your conduct is above reproach.

1.2 The Ethical Standards in Public Life etc. (Scotland) Act 2000, "the Act", provides for Codes of Conduct for local authority councillors and members of relevant public bodies; imposes on councils and relevant public bodies a duty to help their members to comply with the relevant code; and establishes a Standards Commission for Scotland, "The Standards Commission" to oversee the new framework and deal with alleged breaches of the codes.

1.3 The Act requires the Scottish Ministers to lay before Parliament a Code of Conduct for Councillors and a Model Code for Members of Devolved Public Bodies. The Model Code for members was first introduced in 2002 and has now been revised in December 2013 following consultation and the approval of the Scottish Parliament. These revisions will make it consistent with the relevant parts of the Code of Conduct for Councillors, which was revised in 2010 following the approval of the Scottish Parliament.

1.4 As a member of NHS Greater Glasgow & Clyde "the Board", it is your responsibility to make sure that you are familiar with, and that your actions comply with, the provisions of this Code of Conduct which has now been made by the Board.

Appointments to the Boards of Public Bodies

1.5 Public bodies in Scotland are required to deliver effective services to meet the needs of an increasingly diverse population. In addition, the Scottish Government's equality outcome on public appointments is to ensure that Ministerial appointments are more diverse than at present**.** In order to meet both of these aims, a board should ideally be drawn from varied backgrounds with a wide spectrum of characteristics, knowledge and experience. It is crucial to the success of public bodies that they attract the best people for the job and therefore it is essential that a Board's appointments process should encourage as many suitable people to apply for positions and be free from unnecessary barriers. You should therefore be aware of the varied roles and functions of the public body on which you serve and of wider diversity and equality issues. You should also take steps to familiarise yourself with the appointment process that your Board will have agreed with the Scottish Government's Public Appointment Centre of Expertise.

1.6 You should also familiarise yourself with how the public body's policy operates in relation to succession planning, which should ensure public bodies have a strategy to make sure they have the staff in place with the skills, knowledge and experience necessary to fulfil their role economically, efficiently and effectively.

Guidance on the Code of Conduct

1.7 You must observe the rules of conduct contained in this Code. It is your personal responsibility to comply with these and review regularly, and at least annually, your personal circumstances with this in mind, particularly when your circumstances change. You must not at any time advocate or encourage any action contrary to the Code of Conduct.

1.8 The Code has been developed in line with the key principles listed in Section 2 and provides additional information on how the principles should be interpreted and applied in practice. The Standards Commission may also issue guidance. No Code can provide for all circumstances and if you are uncertain about how the rules apply, you should seek advice from the public body. You may also choose to consult your own legal advisers and, on detailed financial and commercial matters, seek advice from other relevant professionals.

1.9 You should familiarise yourself with the Scottish Government publication "On Board – a guide for board members of public bodies in Scotland". This publication will provide you with information to help you in your role as a member of a public body in Scotland and can be viewed on the Scottish Government website.

Enforcement

1.10 Part 2 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 sets out the provisions for dealing with alleged breaches of this Code of Conduct and where appropriate the sanctions that will be applied if the Standards Commission finds that there has been a breach of the Code. Those sanctions are outlined in **Annex A**.

SECTION 2: KEY PRINCIPLES OF THE CODE OF CONDUCT

2.1 The general principles upon which this Code is based should be used for guidance and interpretation only. These general principles are:

Duty
You have a duty to uphold the law and act in accordance with the law and the public trust placed in you. You have a duty to act in the interests of the public body of which you are a member and in accordance with the core functions and duties of that body.

Selflessness
You have a duty to take decisions solely in terms of public interest. You must not act in order to gain financial or other material benefit for yourself, family or friends.

Integrity
You must not place yourself under any financial, or other, obligation to any individual or organisation that might reasonably be thought to influence you in the performance of your duties.

Objectivity
You must make decisions solely on merit and in a way that is consistent with the functions of the public body when carrying out public business including making appointments, awarding contracts or recommending individuals for rewards and benefits.

Accountability and Stewardship
You are accountable for your decisions and actions to the public. You have a duty to consider issues on their merits, taking account of the views of others and must ensure that the public body uses its resources prudently and in accordance with the law.

Openness
You have a duty to be as open as possible about your decisions and actions, giving reasons for your decisions and restricting information only when the wider public interest clearly demands.

Honesty
You have a duty to act honestly. You must declare any private interests relating to your public duties and take steps to resolve any conflicts arising in a way that protects the public interest.

Leadership
You have a duty to promote and support these principles by leadership and example, and to maintain and strengthen the public's trust and confidence in the integrity of the public body and its members in conducting public business.

Respect
You must respect fellow members of your public body and employees of the body and the role they play, treating them with courtesy at all times. Similarly you must respect members of the public when performing duties as a member of your public body.

2.2 You should apply the principles of this Code to your dealings with fellow members of the public body, its employees and other stakeholders. Similarly you should also observe the principles of this Code in dealings with the public when performing duties as a member of the public body.

SECTION 3: GENERAL CONDUCT

3.1 The rules of good conduct in this section must be observed in all situations where you act as a member of the public body.

Conduct at Meetings

3.2 You must respect the chair, your colleagues and employees of the public body in meetings. You must comply with rulings from the chair in the conduct of the business of these meetings.

Relationship with Board Members and Employees of the Public Body (including those employed by contractors providing services)

3.3 You will treat your fellow board members and any staff employed by the body with courtesy and respect. It is expected that fellow board members and employees will show you the same consideration in return. It is good practice for employers to provide examples of what is unacceptable behaviour in their organisation. Public bodies should promote a safe, healthy and fair working environment for all. As a Board member you should be familiar with the policies of the public body in relation to bullying and harassment in the workplace and also lead by exemplar behaviour.

Remuneration, Allowances and Expenses

3.4 You must comply with any rules of the public body regarding remuneration, allowances and expenses.

Gifts and Hospitality

3.5 You must not accept any offer by way of gift or hospitality which could give rise to real or substantive personal gain or a reasonable suspicion of influence on your part to show favour, or disadvantage, to any individual or organisation. You should also consider whether there may be any reasonable perception that any gift received by your spouse or cohabitee or by any company in which you have a controlling interest, or by a partnership of which you are a partner, can or would influence your judgement. The term “gift” includes benefits such as relief from indebtedness, loan concessions or provision of services at a cost below that generally charged to members of the public.

3.6 You must never ask for gifts or hospitality.

3.7 You are personally responsible for all decisions connected with the offer or acceptance of gifts or hospitality offered to you and for avoiding the risk of damage to public confidence in your public body. As a general guide, it is usually appropriate to refuse offers except:

(a) isolated gifts of a trivial character, the value of which must not exceed £50;

(b) normal hospitality associated with your duties and which would reasonably be regarded as appropriate; or

(c) gifts received on behalf of the public body.

3.8 You must not accept any offer of a gift or hospitality from any individual or organisation which stands to gain or benefit from a decision your body may be involved in determining, or who is seeking to do business with your organisation, and which a person might reasonably consider could have a bearing on your judgement. If you are making a visit in your capacity as a member of your public body then, as a general rule, you should ensure that your body pays for the cost of the visit.

3.9 You must not accept repeated hospitality or repeated gifts from the same source.

3.10 Members of devolved public bodies should familiarise themselves with the terms of the Bribery Act 2010 which provides for offences of bribing another person and offences relating to being bribed.

Confidentiality Requirements

3.11 There may be times when you will be required to treat discussions, documents or other information relating to the work of the body in a confidential manner. You will often receive information of a private nature which is not yet public, or which perhaps would not be intended to be public. You must always respect the confidential nature of such information and comply with the requirement to keep such information private.

3.12 It is unacceptable to disclose any information to which you have privileged access, for example derived from a confidential document, either orally or in writing. In the case of other documents and information, you are requested to exercise your judgement as to what should or should not be made available to outside bodies or individuals. In any event, such information should never be used for the purposes of personal or financial gain, or for political purposes or used in such a way as to bring the public body into disrepute.

Use of Public Body Facilities

3.13 Members of public bodies must not misuse facilities, equipment, stationery, telephony, computer, information technology equipment and services, or use them for party political or campaigning activities. Use of such equipment and services etc. must be in accordance with the public body's policy and rules on their usage. Care must also be exercised when using social media networks not to compromise your position as a member of the public body.

Appointment to Partner Organisations

3.14 You may be appointed, or nominated by your public body, as a member of another body or organisation. If so, you are bound by the rules of conduct of these organisations and should observe the rules of this Code in carrying out the duties of that body.

3.15 Members who become directors of companies as nominees of their public body will assume personal responsibilities under the Companies Acts. It is possible that conflicts of interest can arise for such members between the company and the public body. It is your responsibility to take advice on your responsibilities to the public body and to the company. This will include questions of declarations of interest.

SECTION 4: REGISTRATION OF INTERESTS

4.1 The following paragraphs set out the kinds of interests, financial and otherwise which you have to register. These are called "Registerable Interests". You must, at all times, ensure that these interests are registered, when you are appointed and whenever your circumstances change in such a way as to require change or an addition to your entry in the body's Register. It is your duty to ensure any changes in circumstances are reported within one month of them changing.

4.2 The Regulations[1] as amended describe the detail and timescale for registering interests. It is your personal responsibility to comply with these regulations and you should review regularly and at least once a year your personal circumstances. **Annex B** contains key definitions and explanatory notes to help you decide what is required when registering your interests under any particular category. The interests which require to be registered are those set out in the following paragraphs and relate to you. It is not necessary to register the interests of your spouse or cohabitee.

Category One: Remuneration

4.3 You have a Registerable Interest where you receive remuneration by virtue of being:

- employed;
- self-employed;
- the holder of an office;
- a director of an undertaking;
- a partner in a firm; or
- undertaking a trade, profession or vocation or any other work.

4.4 In relation to 4.3 above, the amount of remuneration does not require to be registered and remuneration received as a member does not have to be registered.

4.5 If a position is not remunerated it does not need to be registered under this category. However, unremunerated directorships may need to be registered under category two, "Related Undertakings".

4.6 If you receive any allowances in relation to membership of any organisation, the fact that you receive such an allowance must be registered.

4.7 When registering employment, you must give the name of the employer, the nature of its business, and the nature of the post held in the organisation.

4.8 When registering self-employment, you must provide the name and give details of the nature of the business. When registering an interest in a

[1] SSI - The Ethical Standards in Public Life etc. (Scotland) Act 2000 (Register of Interests) Regulations 2003 Number 135, as amended.

partnership, you must give the name of the partnership and the nature of its business.

4.9 Where you undertake a trade, profession or vocation, or any other work, the detail to be given is the nature of the work and its regularity. For example, if you write for a newspaper, you must give the name of the publication, and the frequency of articles for which you are paid.

4.10 When registering a directorship, it is necessary to provide the registered name of the undertaking in which the directorship is held and the nature of its business.

4.11 Registration of a pension is not required as this falls outside the scope of the category.

Category Two: Related Undertakings

4.12 You must register any directorships held which are themselves not remunerated but where the company (or other undertaking) in question is a subsidiary of, or a parent of, a company (or other undertaking) in which you hold a remunerated directorship.

4.13 You must register the name of the subsidiary or parent company or other undertaking and the nature of its business, and its relationship to the company or other undertaking in which you are a director and from which you receive remuneration.

4.14 The situations to which the above paragraphs apply are as follows:

- you are a director of a board of an undertaking and receive remuneration declared under category one – and
- you are a director of a parent or subsidiary undertaking but do not receive remuneration in that capacity.

Category Three: Contracts

4.15 You have a registerable interest where you (or a firm in which you are a partner, or an undertaking in which you are a director or in which you have shares of a value as described in paragraph 4.19 below) have made a contract with the public body of which you are a member:

(i) under which goods or services are to be provided, or works are to be executed; and

(ii) which has not been fully discharged.

4.16 You must register a description of the contract, including its duration, but excluding the consideration.

Category Four: Houses, Land and Buildings

4.17 You have a registerable interest where you own or have any other right or interest in houses, land and buildings, which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed.

4.18 The test to be applied when considering appropriateness of registration is to ask whether a member of the public acting reasonably might consider any interests in houses, land and buildings could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision making.

Category Five: Interest in Shares and Securities

4.19 You have a registerable interest where you have an interest in shares comprised in the share capital of a company or other body which may be significant to, of relevance to, or bear upon, the work and operation of (a) the body to which you are appointed and (b) the **nominal value** of the shares is:

(i) greater than 1% of the issued share capital of the company or other body; or

(ii) greater than £25,000.

Where you are required to register the interest, you should provide the registered name of the company in which you hold shares; the amount or value of the shares does not have to be registered.

Category Six: Gifts and Hospitality

4.20 You must register the details of any gifts or hospitality received within your current term of office. This record will be available for public inspection. It is not however necessary to record any gifts or hospitality as described in paragraph 3.7 (a) to (c) of this Code.

Category Seven: Non–Financial Interests

4.21 You may also have a registerable interest if you have non-financial interests which may be significant to, of relevance to, or bear upon, the work and operation of the body to which you are appointed. It is important that relevant interests such as membership or holding office in other public bodies, clubs, societies and organisations such as trades unions and voluntary organisations, are registered and described.

4.22 In the context of non-financial interests, the test to be applied when considering appropriateness of registration is to ask whether a member of the public might reasonably think that any non-financial interest could potentially affect your responsibilities to the organisation to which you are appointed and to the public, or could influence your actions, speeches or decision-making.

SECTION 5: DECLARATION OF INTERESTS

General

5.1 The key principles of the Code, especially those in relation to integrity, honesty and openness, are given further practical effect by the requirement for you to declare certain interests in proceedings of the public body. Together with the rules on registration of interests, this ensures transparency of your interests which might influence, or be thought to influence, your actions.

5.2 Public bodies inevitably have dealings with a wide variety of organisations and individuals and this Code indicates the circumstances in which a business or personal interest must be declared. Public confidence in the public body and its members depends on it being clearly understood that decisions are taken in the public interest and not for any other reason.

5.3 In considering whether to make a declaration in any proceedings, you must consider not only whether you will be influenced but whether anybody else would think that you might be influenced by the interest. You must, however, always comply with the **objective test** ("the objective test") which is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice your discussion or decision making in your role as a member of a public body.

5.4 If you feel that, in the context of the matter being considered, your involvement is neither capable of being viewed as more significant than that of an ordinary member of the public, nor likely to be perceived by the public as wrong, you may continue to attend the meeting and participate in both discussion and voting. The relevant interest must however be declared. It is your responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration and you are advised to err on the side of caution. If a board member is unsure as to whether a conflict of interest exits, they should seek advice from the Board chair.

5.5 As a member of a public body you might serve on other bodies. In relation to service on the boards and management committees of limited liability companies, public bodies, societies and other organisations, you must decide, in the particular circumstances surrounding any matter, whether to declare an interest. Only if you believe that, in the particular circumstances, the nature of the interest is so remote or without significance, should it not be declared. You must always remember the public interest points towards transparency and, in particular, a possible divergence of interest between your public body and another body. Keep particularly in mind the advice in paragraph 3.15 of this Code about your legal responsibilities to any limited company of which you are a director.

Interests which Require Declaration

5.6 Interests which require to be declared if known to you may be financial or non-financial. They may or may not cover interests which are registerable under the terms of this Code. Most of the interests to be declared will be your

personal interests but, on occasion, you will have to consider whether the interests of other persons require you to make a declaration. The paragraphs which follow deal with (a) your financial interests (b) your non-financial interests and (c) the interests, financial and non-financial, of other persons.

5.7 You will also have other private and personal interests and may serve, or be associated with, bodies, societies and organisations as a result of your private and personal interests and not because of your role as a member of a public body. In the context of any particular matter you will need to decide whether to declare an interest. You should declare an interest unless you believe that, in the particular circumstances, the interest is too remote or without significance. In reaching a view on whether the objective test applies to the interest, you should consider whether your interest (whether taking the form of association or the holding of office) would be seen by a member of the public acting reasonably in a different light because it is the interest of a person who is a member of a public body as opposed to the interest of an ordinary member of the public.

Your Financial Interests

5.8 You must declare, if it is known to you, any financial interest (including any financial interest which is registerable under any of the categories prescribed in Section 4 of this Code). If, under category one (or category seven in respect of non-financial interests) of section 4 of this Code, you have registered an interest

(a) as an employee of the Board; or
(b) as a Councillor or a Member of another Devolved Public Body where the Council or other Devolved Public Body, as the case may be, has nominated or appointed you as a Member of the Board;

you do not, for that reason alone, have to declare that interest.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

Your Non-Financial Interests

5.9 You must declare, if it is known to you, any non-financial interest if:

(i) that interest has been registered under category seven (Non-Financial Interests) of Section 4 of the Code; or

(ii) that interest would fall within the terms of the objective test.

There is no need to declare an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

The Financial Interests of Other Persons

5.10 The Code requires only your financial interests to be registered. You also, however, have to consider whether you should declare any financial interest of certain other persons.

You must declare if it is known to you any financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;
(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable expenses.

There is no need to declare an interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

You must withdraw from the meeting room until discussion of and voting on the relevant item where you have a declarable interest is concluded. There is no need to withdraw in the case of an interest which is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

5.11 This Code does not attempt the task of defining “relative” or “friend” or “associate”. Not only is such a task fraught with difficulty but is also unlikely that such definitions would reflect the intention of this part of the Code. The key principle is the need for transparency in regard to any interest which might (regardless of the precise description of relationship) be objectively regarded by a member of the public, acting reasonably, as potentially affecting your responsibilities as a member of the public body and, as such, would be covered by the objective test.

The Non-Financial Interests of Other Persons

5.12 You must declare if it is known to you any non-financial interest of:-

(i) a spouse, a civil partner or a co-habitee;
(ii) a close relative, close friend or close associate;
(iii) an employer or a partner in a firm;

(iv) a body (or subsidiary or parent of a body) of which you are a remunerated member or director;
(v) a person from whom you have received a registerable gift or registerable hospitality;
(vi) a person from whom you have received registerable election expenses.

There is no need to declare the interest if it is so remote or insignificant that it could not reasonably be taken to fall within the objective test.

There is only a need to withdraw from the meeting if the interest is clear and substantial.

Making a Declaration

5.13 You must consider at the earliest stage possible whether you have an interest to declare in relation to any matter which is to be considered. You should consider whether agendas for meetings raise any issue of declaration of interest. Your declaration of interest must be made as soon as practicable at a meeting where that interest arises. If you do identify the need for a declaration of interest only when a particular matter is being discussed you must declare the interest as soon as you realise it is necessary.

5.14 The oral statement of declaration of interest should identify the item or items of business to which it relates. The statement should begin with the words “I declare an interest”. The statement must be sufficiently informative to enable those at the meeting to understand the nature of your interest but need not give a detailed description of the interest.

Frequent Declarations of Interest

5.15 Public confidence in a public body is damaged by perception that decisions taken by that body are substantially influenced by factors other than the public interest. If you would have to declare interests frequently at meetings in respect of your role as a board member you should not accept a role or appointment with that attendant consequence. If members are frequently declaring interests at meetings then they should consider whether they can carry out their role effectively and discuss with their chair. Similarly, if any appointment or nomination to another body would give rise to objective concern because of your existing personal involvement or affiliations, you should not accept the appointment or nomination.

Dispensations

5.16 In some very limited circumstances dispensations can be granted by the Standards Commission in relation to the existence of financial and non-financial interests which would otherwise prohibit you from taking part and voting on matters coming before your public body and its committees.

5.17 Applications for dispensations will be considered by the Standards Commission and should be made as soon as possible in order to allow proper

consideration of the application in advance of meetings where dispensation is sought. You should not take part in the consideration of the matter in question until the application has been granted.

SECTION 6: LOBBYING AND ACCESS TO MEMBERS OF PUBLIC BODIES

Introduction

6.1 In order for the public body to fulfil its commitment to being open and accessible, it needs to encourage participation by organisations and individuals in the decision-making process. Clearly however, the desire to involve the public and other interest groups in the decision-making process must take account of the need to ensure transparency and probity in the way in which the public body conducts its business.

6.2 You will need to be able to consider evidence and arguments advanced by a wide range of organisations and individuals in order to perform your duties effectively. Some of these organisations and individuals will make their views known directly to individual members. The rules in this Code set out how you should conduct yourself in your contacts with those who would seek to influence you. They are designed to encourage proper interaction between members of public bodies, those they represent and interest groups.

Rules and Guidance

6.3 You must not, in relation to contact with any person or organisation that lobbies do anything which contravenes this Code or any other relevant rule of the public body or any statutory provision.

6.4 You must not, in relation to contact with any person or organisation who lobbies, act in any way which could bring discredit upon the public body.

6.5 The public must be assured that no person or organisation will gain better access to or treatment by, you as a result of employing a company or individual to lobby on a fee basis on their behalf. You must not, therefore, offer or accord any preferential access or treatment to those lobbying on a fee basis on behalf of clients compared with that which you accord any other person or organisation who lobbies or approaches you. Nor should those lobbying on a fee basis on behalf of clients be given to understand that preferential access or treatment, compared to that accorded to any other person or organisation, might be forthcoming from another member of the public body.

6.6 Before taking any action as a result of being lobbied, you should seek to satisfy yourself about the identity of the person or organisation that is lobbying and the motive for lobbying. You may choose to act in response to a person or organisation lobbying on a fee basis on behalf of clients but it is important that you know the basis on which you are being lobbied in order to ensure that any action taken in connection with the lobbyist complies with the standards set out in this Code.

6.7 You should not accept any paid work:-

(a) which would involve you lobbying on behalf of any person or organisation or any clients of a person or organisation.

(b) to provide services as a strategist, adviser or consultant, for example, advising on how to influence the public body and its members. This does not prohibit you from being remunerated for activity which may arise because of, or relate to, membership of the public body, such as journalism or broadcasting, or involvement in representative or presentational work, such as participation in delegations, conferences or other events.

6.8 If you have concerns about the approach or methods used by any person or organisation in their contacts with you, you must seek the guidance of the public body.

Issued - October 2014
Incorporated into NHSGGC Standing Orders – April 2015

ANNEX A

SANCTIONS AVAILABLE TO THE STANDARDS COMMISSION FOR BREACH OF THE CODE

(a) Censure – the Commission may reprimand the member but otherwise take no action against them;

(b) Suspension – of the member for a maximum period of one year from attending one or more, but not all, of the following:

i) all meetings of the public body;

ii) all meetings of one or more committees or sub-committees of the public body;

(iii) all meetings of any other public body on which that member is a representative or nominee of the public body of which they are a member.

(c) Suspension – for a period not exceeding one year, of the member's entitlement to attend all of the meetings referred to in (b) above;

(d) Disqualification – removing the member from membership of that public body for a period of no more than five years.

Where a member has been suspended, the Standards Commission may direct that any remuneration or allowance received from membership of that public body be reduced, or not paid.

Where the Standards Commission disqualifies a member of a public body, it may go on to impose the following further sanctions:

(a) Where the member of a public body is also a councillor, the Standards Commission may disqualify that member (for a period of no more than five years) from being nominated for election as, or from being elected, a councillor. Disqualification of a councillor has the effect of disqualifying that member from their public body and terminating membership of any committee, sub-committee, joint committee, joint board or any other body on which that member sits as a representative of their local authority.

(b) Direct that the member be removed from membership, and disqualified in respect of membership, of any other devolved public body (provided the members' code applicable to that body is then in force) and may disqualify that person from office as the Water Industry Commissioner.

In some cases the Standards Commission do not have the legislative powers to deal with sanctions, for example if the respondent is an executive member of the board or appointed by the Queen. Sections 23 and 24 of the Ethical Standards in Public Life etc. (Scotland) Act 2000 refer.

Full details of the sanctions are set out in Section 19 of the Act.

ANNEX B

DEFINITIONS

"Chair" includes Board Convener or any person discharging similar functions under alternative decision making structures.

"Code" code of conduct for members of devolved public bodies

"Cohabitee" includes a person, whether of the opposite sex or not, who is living with you in a relationship similar to that of husband and wife.

"Group of companies" has the same meaning as "group" in section 262(1) of the Companies Act 1985. A "group", within s262 (1) of the Companies Act 1985, means a parent undertaking and its subsidiary undertakings.

"Parent Undertaking" is an undertaking in relation to another undertaking, a subsidiary undertaking, if a) it holds a majority of the rights in the undertaking; or b) it is a member of the undertaking and has the right to appoint or remove a majority of its board of directors; or c) it has the right to exercise a dominant influence over the undertaking (i) by virtue of provisions contained in the undertaking's memorandum or articles or (ii) by virtue of a control contract; or d) it is a councillor of the undertaking and controls alone, pursuant to an agreement with other shareholders or councillors, a majority of the rights in the undertaking**.**

"A person" means a single individual or legal person and includes a group of companies.

"Any person" includes individuals, incorporated and unincorporated bodies, trade unions, charities and voluntary organisations.

"**Public body"** means a devolved public body listed in Schedule 3 of the Ethical Standards in Public Life etc. (Scotland) Act 2000, as amended.

"Related Undertaking" is a parent or subsidiary company of a principal undertaking of which you are also a director. You will receive remuneration for the principal undertaking though you will not receive remuneration as director of the related undertaking.

"Remuneration" includes any salary, wage, share of profits, fee, expenses, other monetary benefit or benefit in kind. This would include, for example, the provision of a company car or travelling expenses by an employer.

"Spouse" does not include a former spouse or a spouse who is living separately and apart from you.

"Undertaking" means:
a) a body corporate or partnership; or
b) an unincorporated association carrying on a trade or business, with or without a view to a profit.

Standing Orders for the Proceedings and Business of NHS Greater Glasgow and Clyde

NHS GREATER GLASGOW AND CLYDE

STANDING ORDERS FOR THE PROCEEDINGS
AND BUSINESS OF NHS GREATER GLASGOW AND CLYDE

1. General

(1) These Standing Orders for regulation of the conduct and proceedings of NHS Greater Glasgow and Clyde (the common name for Greater Glasgow Health Board) and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 and subsequent Statutory Instruments [the Regulations]. Members of the Board are expected to subscribe to comply with:-

- the NHS Greater Glasgow and Clyde Code of Conduct made under the Ethical Standards in Public Life etc (Scotland) Act 2000, which shall be regarded as if incorporated into these Standing Orders.

(2) Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

(3) Any one or more of the Board's Standing Orders may be suspended at a meeting of the Board on a duly seconded motion, incorporating the reasons for suspension, if carried by a majority of Members present.

(4) Any one or more of the Board's Standing Orders may be varied or revoked at a meeting of the Board by a majority of Members present and voting, provided the agenda for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment.

(5) The Head of Corporate Governance Administration shall provide a copy of these Standing Orders to all Members of the Board on appointment.

2. Membership

The membership of the Board shall be those persons appointed by the Scottish Ministers and comprise the Chair, Vice Chair, Non-Executive and Executive Directors, as determined by the Regulations.

3. Chairperson

(1) At every meeting of the Board if the Chair is absent from any meeting the Vice-Chair, if present, shall preside. If both the Chair and Vice Chair are absent, a Non-Executive Director chosen at the meeting shall preside.

(2) The duty of the person presiding at a meeting of the Board or its Committees is to ensure that the Standing Orders are observed, to

preserve order, to ensure fairness between Members and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

(3) The Chair may resign office at any time on giving notice to the Scottish Ministers and shall hold office in accordance with appointment by Scottish Ministers unless he/she is disqualified.

4. Vice-Chair

(1) The Board Chair shall nominate to the Cabinet Secretary for Health and Sport a Non-Executive Director to be Vice-Chair and the person appointed shall, so long as they remain a Member of the Board, continue in office for a 4-year term.

(2) The Member appointed as Vice Chair may at any time resign from the office of Vice-Chair by giving notice in writing to the Chair and the Members may appoint another Non-Executive Director as Vice-Chair in accordance with Standing Order 4(1).

(3) Where the Chair has died, ceased to hold office, or is unable to perform their duties due to illness, absence from Scotland or for any other reason, the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board and references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to the Vice-Chair.

5. Resignation and Removal of Members

(1) A Member may resign office at any time during the period of appointment by giving notice in writing to the Scottish Ministers to this effect.

(2) If the Scottish Ministers consider that it is not in the interests of the health service that a Member of a Board should continue to hold that office they may forthwith terminate that person's appointment.

(3) If a Member has not attended any meeting of the Board, or of any Committee of which they are a Member, for a period of six consecutive months, the Scottish Ministers shall forthwith terminate that person's appointment unless satisfied that -

(a) the absence was due to illness or other reasonable cause; and

(b) the Member will be able to attend meetings within such period as the Scottish Ministers consider reasonable.

(4) Where a Member who was appointed for the purposes of paragraph 2A of Schedule 1 to the NHS (Scotland) Act 1978 (representative of University) ceases to hold the post in a university with a medical or dental school, which was held at the time of appointment for those purposes,

the Scottish Ministers may terminate the appointment of that person as a Member.

(5) Where any Member becomes disqualified in terms of Regulation 6 of the Regulations that Member shall forthwith cease to be a Member.

6. Ordinary Meetings

(1) The Board shall meet at least 4 times in the year and meetings of the Board, unless otherwise determined in relation to any particular meeting, at a date and time determined by the Board or the Chair and specified in the notice calling the meeting.

(2) Subject to Standing Order 7 below, the Chair (or Executive Director of the Board who may sign on the Chairperson's behalf) shall convene meetings of the Board by issuing to each Member, not less than 5 working days before the meeting, a notice detailing the place, time and business to be transacted at the meeting, together with copies of all relevant papers (where available at the time of issue of the agenda).

(3) Meetings of a Board may be conducted in any other way in which each member is enabled to participate although not present with others in such a place.

(4) A meeting shall be conducted by virtue of the above (paragraph 6.3) only on the direction of the Chair/Vice-Chair of the Board.

(5) The notice shall be sent to every Member electronically or sent by post to the place of residence of members, or such other address as notified by them to the Head of Corporate Governance and Administration.

(6) Lack of service of the notice on any Member shall not affect the validity of a meeting.

(7) A publically available notice of Board meetings shall be given by the Person convening the meeting in accordance with the provisions of the Public Bodies (Admission to Meetings) Act 1960.

7. Decisions Reserved for the Board and Scheme of Delegation

(1) The matters set out in the Annex to these Standing Orders are matters, which may only be determined at a meeting of the Board. All other matters are delegated in accordance with the Scheme of Delegation, remitted to a Standing Committee of the NHS Board or to the Health & Care Social Partnership Integrated Joint Boards.

(2) Notwithstanding (1) the Board may, at anytime, request reports on any matter or may decide to reserve any particular decision for itself.

8. Requisitioned (Special) Meetings

(1) The Chair of the Board may call a meeting of the Board at any time and shall do so on receipt of a requisition in writing for that purpose which specifies the business to be transacted at the meeting and is signed by one third of the whole number of Members of the Board.

(2) In the case of a requisitioned meeting, the meeting shall be held within 14 days of receipt of the requisition and no business shall be transacted at the meeting other than that specified in the requisition.

(3) If the Chair refuses to call a meeting of the Board after a requisition for that purpose, or if, without so refusing, does not call a meeting within 7 days after such a requisition has been presented, those Members who presented the requisition may forthwith call a meeting by signing the notice calling the meeting provided that no business shall be transacted at the meeting other than that specified in the requisition.

9. Conduct of Meetings

(1) No business shall be transacted at a meeting of the Board unless there are present, and entitled to vote, at least one third of the whole number of Members, of whom at least seven are Non-Executive Directors.

(2) No business shall be transacted at any meeting of the Board other than that specified in the agenda except on grounds of urgency and with the consent of the majority of the Members of the Board present. Any request for the consideration of an additional item of business shall be raised at the start of the meeting and the consent of the majority of Members for the inclusion must be obtained at that time.

(3) All acts of, and all questions coming and arising before, the Board shall be done and decided by a majority of the Members of the Board present and voting at a meeting of the Board. Majority agreement may be reached by consensus without a formal vote. Where there is doubt, a formal vote shall be taken by Members by a show of hands, or by ballot, or any other method determined by the person presiding at the meeting.

(4) In the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote.

(5) Where a post of Executive Director is shared by more than one person:

(a) Those persons, or any one of them, shall be entitled to attend any meeting of the Board

(b) Where more than one of those persons attend they shall be entitled to a collective vote on any single topic raised at the meeting provided they have agreed between themselves as to the way in which the vote is to be cast

c) If they do not so agree, no vote shall be cast by them

d) The presence of any one or more of those persons shall count as the presence of one person for the purpose of the quorum.

(6) A motion which contradicts a previous decision of the Board shall not be competent within six months of the date of such decision, unless submitted in the minutes of a Committee, or notice of the proposed variation is provided in the notice of the Board meeting. Where a decision is rescinded, it shall not affect or prejudice any action, proceeding or liability which may have been competently done or undertaken before such decision was rescinded.

10. Minutes

(1) The names of Members and other persons present at a meeting of the Board, or of a Committee of the Board, shall be recorded in the minutes of the meeting.

(2) Minutes of the proceedings of meetings of the Board and its Committees and decisions thereof shall be drawn up by the Head of Corporate Governance Administration (or their authorised nominee) and be submitted to the next ensuing meeting of the Board or relevant Committee for approval as to their accuracy.

11. Order of Debate

(1) Any motion or amendment shall, if required by the Chair, be reduced to writing, and after being seconded, shall not be withdrawn without the leave of the Board. No motion or amendment shall be spoken upon, except by the mover, until it has been seconded.

(2) After debate, the mover of any original motion shall have the right to reply. In replying they shall not introduce any new matter, but shall confine himself/herself strictly to answering previous observations, and, immediately after they reply, the question shall be put by the Chair without further debate.

(3) Any Member in seconding a motion or an amendment may reserve their speech for a later period of the debate.

(4) When more than one amendment is proposed, the Chair of the meeting shall decide the order in which amendments are put to the vote. All amendments carried shall be incorporated in the original motion which shall be put to the meeting as a substantive motion.

(5) A motion to adjourn any debate on any question or for the closure of a debate shall be moved and seconded and put to the meeting without discussion. Unless otherwise specified in the motion, an adjournment of any debate shall be to the next meeting.

12. Adjournment of Meetings

A meeting of the Board, or of a Committee of the Board, may be adjourned by a motion, which shall be moved and seconded and be put to the meeting without discussion. If such a motion is carried, the meeting shall be adjourned until the next scheduled meeting or to such day, time and place as may be specified in the motion.

13. Declaration of Interests and Register of Interests

(1) Members of the NHS Board shall observe all their obligations under the Code of Conduct for Members of the NHS Greater Glasgow and Clyde made under the Ethical Standards in Public Life etc. (Scotland) Act 2000.

(2) In case of doubt as to whether any interest or matter should be the subject of a notice or declaration under the Code, Members should err on the side of caution and submit a notice/make a declaration or seek guidance from the Standards Commission, the Chair or Head of Corporate Governance and Administration as to whether a notice/declaration should be made.

(3) The key principles are integrity, honesty and openness. Members must consider whether they will be influenced or that anybody else would think that they might be influenced by the interest. The "Objective Test" is whether a member of the public, with knowledge of the relevant facts, would reasonably regard the interest as so significant that it is likely to prejudice a Member's discussion or decision-making. It is the Member's responsibility to judge whether an interest is sufficiently relevant to particular proceedings to require a declaration of interest. On declaring an interest, a Member's participation in the meeting, or observation of the meeting or withdrawal from the meeting will be determined by the significance of the interest declared. The final decision, if required, will be made by the Chair on the advice of the Head of Corporate Governance and Administration.

4) Where a Member requires an interest to be amended, this shall be notified to the Head of Corporate Governance and Administration in writing by giving notice in writing using the standard form available from the Head of Corporate Governance and Administration within one month of the interest changing. The Head of Corporate Governance and Administration (or authorised nominee) will write to Members every six months to request them to formally review their declaration.

(5) Persons on appointment to the NHS Board as Members shall have one month to give notice of any registerable interests under the Code, or to make a declaration that they have no registerable interest in each

relevant category as specified in the standard form to be supplied by the Head of Corporate Governance and Administration.

(6) The Head of Corporate Governance and Administration will be responsible for maintaining the Register of Interests and for ensuring it is available for public inspection at the principal offices of the NHS Board at all reasonable times and will be included on the NHS Board's internet site.

(7) The Register shall include information on:

(i) the date of receipt of every notice:

(ii) the name of the person who gave the notice which forms the entry in the Register; and

(iii) a statement of the information contained in the notice, or a copy of the Notice.

(8) Members shall make a declaration of any gifts or hospitality received in their capacity as a Member of the NHS Board. Such declarations shall be made to the Head of Corporate Governance and Administration who shall make them available for public inspection at all reasonable times at the headquarters of the NHS Board and on the NHS Board's internet site www.nhsggc.org.uk.

(9) The Head of Corporate Governance and Administration (or authorised nominee) shall maintain Registers of Interest and Gifts & Hospitality under the provisions of NHS Circular HDL (2003) 62.

The Registers shall be made publicly available on request.

14. Suspension of Members

Any Member who disregards the authority of the Chair, obstructs the meeting, or conducts themselves offensively shall be suspended for the remainder of the meeting, if a motion which is proposed and seconded (which shall be determined without discussion) for their suspension is carried. Any person so suspended shall leave the meeting immediately and shall not return without the consent of the meeting. If a person so suspended refuses, when required by the Chair to leave the meeting, the meeting will be suspended until such time as they leave.

15. Admission of Public and Press

(1) Members of the public and representatives of the press shall be notified of meetings and shall be admitted to meetings of the Board in accordance with the provision of the Public Bodies (Admission to Meetings) Act 1960.

(2) Members of the public and representatives of the press admitted to meetings of the Board may be excluded from any meeting by decision of the Board, where, in the opinion of the majority of Members present, publicity would be prejudicial to the public interest by reason of the confidential nature of the business to be transacted, or such other special reason as may be specified in the decision.

(3) Representatives of the press and members of the public admitted to meetings shall require the authority of the Board for each occasion they may wish to record the proceedings of the meeting other than by written notes.

(4) Members of the public may, at the Chairperson's sole discretion, be permitted to address the Board or respond to questions from Members of the Board, but shall not generally have a right to participate in the debate at Board Meetings.

(5) Nothing in this Standing Order shall preclude the Chair from requiring the removal from a meeting of any person or persons who persistently disrupts the proceedings of a meeting.

16. Execution of Documents

(1) Any document or proceeding which requires to approved by the Board shall be signed by one Member of the Board, the Head of Corporate Governance and Administration (or their authorised nominee) and the Director of Finance (or their authorised nominee).

(2) The Director of Finance shall be responsible for maintaining a record of officers authorised to sign documents on behalf of the Board in accordance with provisions contained within Standing Financial Instructions.

(3) Where a document requires, for the purpose of any enactment or rule of law relating to the approval of documents under the Law of Scotland, or otherwise, requires to be approved on behalf of the Board, it shall be signed by an Executive Director of the NHS Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the provisions of the Requirements of Writing (Scotland) Act 1995. Before approving any document the person approving the document shall satisfy themselves that all necessary approvals in terms of the Board's procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

(4) Scottish Ministers shall direct on which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

(5) Any authorisation to sign documents granted to an officer of the Board

shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

17. Committees

(1) Subject to any direction issued by Scottish Ministers, the Board shall appoint such Committees and Sub-Committees as it thinks fit. The remits of the NHS Board and Committees, their quora and reporting arrangements shall be reviewed annually by the Board.

(2) Subject to any direction or regulation issued by Scottish Ministers, Committees of the Board may co-opt persons as Members of Board Committees and Sub-Committees, as and when required.

(3) The Chair of a Committee may call a meeting of that Committee any time after discussion with the Board Chair and Chief Executive or when requested to do so by the Board.

(4) The Standing Orders, so far as applicable, shall be the rules and regulations for the proceedings of formally constituted Committees and Sub-Committees, subject always to the following additional provisions:

(a) The Chair and Vice-Chair of the Board and the Chief Executive of the Board shall have the right to attend all Committees except where the constitution of such Committees precludes such an arrangement.

(b) Meetings of Committees and Sub-Committees shall not be open to the public and press unless the Board decides otherwise in respect to a particular Committee or a particular meeting of a Committee.

(c) Committees of the Board and the Chairs thereof shall be appointed by the Board Chair and endorsed annually at the meeting of the Board in April or at a meeting to be held as soon as convenient thereafter. Unforeseen vacancies in the membership of Committees thereof shall be filled, so far as practicable by the Board Chair, and endorsed by the Board at the next scheduled meeting following a vacancy occurring.

(d) Committees of the Board may appoint Sub-Committees and Chairs thereof as may be considered necessary in discussion with the Chair and Chief Executive.

(e) Minutes of the proceedings of Committees shall be drawn up by the Head of Corporate Governance and Administration (or their authorised nominee) and submitted to the Board at the first scheduled meeting held not less than seven days after the meeting of the Committee for the purpose of advising the Board of decisions taken.

(f) Minutes of meetings of Sub-Committees shall be submitted to their Parent Committee at the first scheduled meeting of the parent Committee held not less than seven days after the meeting of the Sub-Committee for the purpose of advising the Committee of decisions taken.

(g) A Committee, or Sub-Committee may, notwithstanding that a matter is delegated to it, direct that a decision shall be submitted by way of recommendation to the Board or parent Committee for approval.

Version Control

December 2005
Revised April 2007
Reviewed April 2008
Revised April 2009
Reviewed April 2010
Reviewed April 2011
Reviewed August 2012
Reviewed April 2013
Reviewed April 2014
Revised April 2015
Revised June 2016
Revised August 2017
Revised June 2019

Annexe 1 to

SOs

NHS GREATER GLASGOW AND CLYDE

MATTERS RESERVED FOR THE BOARD

Background

As defined in the NHS Circular HDL(2003) 11 "Moving Towards Single System Working", Greater Glasgow and Clyde NHS Board is a board of governance, delivering a corporate approach to collective decision making based on the principles of partnership working and devolution of powers. Local leadership will be supported by delegating financial and management responsibility as far as is possible consistent with the Board's own responsibility for governance.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Board to delegate some of its functions to an Integration Joint Board in order to create a single system for local joint strategic commissioning of health and social care services. The Integration Joint Board may, by direction, require the Board to carry out a function delegated to the integrated authority. These functions, which the Board is directed to carry out by the Integration Joint Board, are subject to the Board's Scheme of Delegation.

The Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of its affairs and that of its operating sectors and partnerships, including compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has an ongoing responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

The Board is required to ensure that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually, and to report publicly on its compliance with the principles of corporate governance codes.

The following matters shall be reserved for agreement by the Board: -

1. Improving the Health of the population (shared responsibility with the Integration Joint Partnership Boards (HSCPs);
2. Setting strategic direction and development;
3. Development and Implementation of the Annual Operational Plan;

4. Monitoring of aggregated/exception reports from the Acute Services Committee, the Finance Planning and Performance Committee and HSCP IJBs on key performance indicators;
5. Resource Allocation (for both Capital and Revenue resource allocation);
6. Approval of Annual Accounts;
7. Scrutiny of Public Private Partnerships;
8. Approve appointment process of Executive Directors;
9. NHS Statutory Approvals;
10. Corporate Objectives;
11. Sets Values of the organization;
12. Corporate governance framework including
    - Standing Orders
    - Establishment, remit, and reporting arrangements of all Board Standing Committees
    - Scheme of Delegation
    - Standing Financial Instructions

NHS Greater Glasgow and Clyde Standing Financial Instructions

Standing Financial Instructions

Lead Manager	Head of Financial Governance
Responsible Director	Director of Finance
Approved By	NHSGGC Board
Date Approved	tba
Date for Review	April 2020
Replaces Previous Version	Standing Financial Instructions - 9th Revision, approved April 2018

NHS Greater Glasgow & Clyde
Standing Financial Instructions

Contents

SECTION 1

INTRODUCTION AND CODE OF CONDUCT FOR STAFF

1.1 GENERAL

These Standing Financial Instructions (SFIs or Instructions) detail the financial responsibilities, policies and procedures to be adopted by NHS Greater Glasgow and Clyde (NHSGGC). They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness.

These Instructions are issued in accordance with the National Health Service (Financial Provisions) (Scotland) Regulations 1974, Regulation 4, together with the subsequent guidance and requirements contained in NHS Circular No. 1974 (GEN) 88 and annex, and MEL(1994) 80, for the regulation of the conduct of the Board, its members and officers, in relation to financial matters. They also reflect the provisions of the Public Bodies (Joint Working) (Scotland) Act 2014.

They will have effect as if incorporated in the Standing Orders for the Proceedings and Business of the Board.

The SFIs identify the financial responsibilities that apply to everyone working for NHSGGC and its constituent organisations. They do not provide detailed procedural advice. However, financial procedural notes will be prepared to reflect the requirement of these SFIs. These statements should therefore be read in conjunction with the relevant financial operating procedures.

Departmental heads with financial responsibilities will fulfil these responsibilities in a way that complies with the requirements of these Instructions, and will put in place, and maintain procedures that comply with the SFIs.

The SFIs are in themselves a component of a wider Risk Management Strategy that seeks to safeguard all of the processes of NHSGGC.

Failure to comply with SFIs is a disciplinary matter which could result in dismissal.

Nothing in these SFIs shall be held to override any legal requirement or SGHSCD directive.

1.2 CODE OF CONDUCT FOR STAFF

The Code of Conduct under the Ethical Standards in Public Life (Scotland) Act 2000 is issued to all NHSGGC Board Members on appointment and a condition of their appointment is acceptance of and compliance with the Code.

The Code of Conduct for Staff (the Code) incorporates the following documents:

- The Standards of Business Conduct for NHS Staff [NHS Circular MEL (1994) 48];
- A Common Understanding: Guidance on Joint Working between NHS Scotland and the Pharmaceutical Industry [NHS Circular HDL (2003) 62];
- The NHSGGC Whistleblowing Policy
- The NHSGGC Fraud Policy.

The Code provides instruction and guidance on how staff should maintain strict ethical standards in the conduct of NHSGGC business. It forms part of the NHSGGC standard contract of employment and all staff are required to adhere to the Code. Key principles underpinning the Code include the following:

NHSGGC is committed to the three essential public values.

Accountability — Everything done by those who work in the organisation must be able to stand the tests of parliamentary scrutiny, public judgments on propriety and meet professional codes of conduct.

Probity — Absolute honesty and integrity should be exercised in dealing with NHS patients, staff, assets, suppliers and customers.

Openness — The Board's activities should be sufficiently public and transparent to promote confidence between the Board and its patients, its staff and the public.

To achieve and hold these values, the following key principles should be followed by staff in all their official business.

- Staff should ensure that the interests of patients remain paramount at all times.
- Staff should be impartial and honest in the conduct of their business and should remain beyond suspicion at all times. The Bribery Act 2010 makes it an offence to:
    a) Offer, promise or give a bribe or
    b) Request, agree to receive or accept a bribe in return for improperly performing a function or activity.
- Staff should use the public funds entrusted to them to the best advantage of the service, always ensuring value for money.
- Staff should not abuse their official position for personal gain or to benefit their family and/or friends; or seek to advantage or further their private business or other interests in the course of their official duties.

In the first instance, employees should contact their line manager or Head of Department or Director for advice on the application of the Code.

1.3 TERMINOLOGY

Any expression to which a meaning is given in the Health Service Acts or in the financial regulations made under the Acts shall have the same meaning in these Instructions; and

1. "NHS Greater Glasgow and Clyde" (NHSGGC) is the common name used to define the entity/organisation whose legal name is Greater Glasgow Health Board.
2. "Board" means the Management Committee of NHSGGC/Greater Glasgow Health Board, or such other Committee of the Board to which powers have been delegated.
3. "Budget" means an allocation of resources by the Board, Chief Executive or other officer with delegated authority expressed in financial terms, for the purposes of carrying out, over a specific period, a function or group of functions of the NHSGGC Board.
4. "Chief Officer" means any officer who is directly accountable to the Chief Executive i.e. Directors, Chief Officers/Directors of Divisions/HSCPs and some Heads of Department.
5. "Budget Holder" means the Chief Officer or employee with delegated authority to manage finances (income and expenditure) for a specific area of the organisation.
6. "SGHSCD" means Scottish Government Health and Social Care Directorates.

7. "Supervisory Body" means a committee established by the Board with delegated authority to discharge the Board's responsibilities under the Adults with Incapacity (Scotland) Act 2000.
8. "Integration Joint Board" or "Joint Board" means the body corporate established by Scottish Ministers as a consequence of an approved integration plan.
9. Health and Social Care Partnership (HSCP) is the common name for an Integration Joint Board.

1.4 RESPONSIBILITIES AND DELEGATION

The Board will exercise financial supervision and control by:-

1. formulating the financial strategy;
2. requiring the submission and approval of annual budgets within approved allocations;
3. approving SFIs;
4. defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation.

All directors and employees have a general responsibility for the security of the property of NHSGGC, for avoiding loss, for economy and efficiency in the use of resources and for complying with the requirements of these Instructions. Should any difficulty arise regarding their interpretation or application then the advice of the Director of Finance or authorised nominee must be sought before action is taken.

It is the duty of the Chief Executive, managers and heads of department, to ensure that existing staff and all new appointees are informed of their responsibilities within these Instructions. Breaches of these Instructions will be reported to the Director of Finance.

Within these SFIs it is acknowledged that the Chief Executive is ultimately accountable to the Board for ensuring that NHSGGC meets its obligations to perform its functions within the available financial resources. The Chief Executive has overall responsibility for NHSGGC's activities and is responsible to the Board for ensuring that its financial obligations and targets are met.

The Chief Executive and Director of Finance will, as far as possible, delegate their detailed responsibilities but they will remain accountable to the Board for financial control. The Chief Executive is the Accountable Officer for NHSGGC's Finances, as set out in the Memorandum to National Health Service Accountable Officers by the SGHSCD in accordance with the Public Finance and Accountability (Scotland) Act 2000.

Without prejudice to the functioning of any other officer of NHSGGC, the Director of Finance will ensure:

1. the design, implementation and supervision of systems of financial control including the adoption of Standing Financial Instructions and the maintenance of effective internal audit arrangements;
2. the preparation, documentation, implementation and maintenance of NHSGGC's financial policies, procedures and systems in support of a comprehensive control environment;
3. the co-ordination of any corrective action necessary to further these policies, procedures and systems;

4. the preparation and maintenance of such accounts, costs, estimates etc. for the purposes of carrying out NHSGGC's duties and establishing with reasonable accuracy NHSGGC's financial position;

5. the provision of financial advice to NHSGGC's Board and its officers;

6. the accurate and timely submission to the Scottish Government Health and Social Care Directorates of Annual Accounts and such other reports, returns and monitoring information as may be required to allow the SGHSCD to discharge its responsibilities.

1.5 MODIFICATION AND INTERPRETATION

The Director of Finance may make minor changes to terminology contained in, or presentation of, these SFIs as required, without seeking approval. Any such changes will be reported to the NHS Board at the time of the annual review of these Instructions.

Wherever the title of Chief Executive or Chief Officer is used in these Instructions, it will be deemed to include such other directors or employees who have been duly authorised to represent them.

Whenever the term "employee" is used it shall be deemed to include directors or employees of third parties contracted to NHSGGC when acting on behalf of NHSGGC.

All references in these Instructions to the singular form will be read as equally applicable to the plural.

NHSGGC has adopted use of the non-gendered pronoun 'they' and this shall be read as being applicable and inclusive of all gender identities.
Any reference to any legislation, provision or guidance should be construed as applying equally to any amendment or later publication of that legislation, provision or guidance.

Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board without further intimation or action by the Board.

SECTION 2

ALLOCATIONS, BUSINESS PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

2.1 INTRODUCTION

NHSGGC will perform its functions within the total of funds allocated by Scottish Ministers and any other source of recognised income. All plans, financial approvals and control systems will be designed to meet this obligation.

2.2 ALLOCATIONS AND REVENUE PLAN

The Director of Finance will:

1. at least once per year, review the bases and assumptions used for distributing allocations and ensure that these are reasonable and realistic and secure NHSGGC's entitlement to funds;

2. submit Financial Plans to the Board for approval, for both revenue and capital expenditure, detailing sources of income and the proposed application of those funds, including any sums to be held in reserve;

3. ensure that the proposed application of funds reconciles to the allocations received and other sources of income;

4. ensure that the Financial Plan states clearly the significant assumptions on which it is based and details any major changes in activity, delivery of service or resources required to achieve the Plan;

5. ensure that the financial contribution to the Health and Social Care Partnership (HSCP) integrated budget is in accordance with the Integration Plan;

6. ensure that the Financial Plan reflects the objectives set out in the Corporate Plan, the Strategic Plans developed by HSCPs and the Annual Operational Plan;

7. regularly report to the Board on significant changes to the initial allocation and the uses of such funds.

2.3 PREPARATION AND APPROVAL OF BUDGETS

The Director of Finance will, on behalf of the Chief Executive, prepare and submit budgets for approval by the Board. Such budgets will predominantly cover allocations to Divisions and HSCPs to provide services for the delivery of healthcare and will also identify funding required for the operation of the corporate functions of NHSGGC. Such budgets will:

1. be in accordance with the aims and objectives set out in the Corporate Plan and the Strategic Plans developed by HSCPs;

2. accord with workload and manpower plans;

3. be produced following discussion with appropriate Divisional representatives and other budget holders;

4. be prepared within the limits of available funds; and

5. identify potential risks.

The Director of Finance will establish procedures to monitor financial performance against budget and the Financial Plan, periodically review them and report to the Board. This report will provide an explanation of significant variances from budget and the Financial Plan together with a forecast outturn for the year. It will detail any corrective action required to achieve the Board's financial targets for the year.

All budget holders, and managers, must provide information as required by the Director of Finance to enable budgets to be compiled and monitored, using appropriately defined reporting formats.

The Director of Finance has a responsibility to ensure that adequate financial advice is provided on an ongoing basis to budget holders to help them discharge their budgetary control responsibilities effectively and efficiently.

2.4 BUDGETARY DELEGATION

The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities.

This reflects the nature of partnership working, both with other public sector organisations and private agencies providing healthcare services [See also Sections 7 and 17 of these Instructions].

This delegation must be in writing and be accompanied by a clear definition of:

1. the amount of the budget;

2. the purpose(s) of each budget heading;

3. individual and group responsibilities;

4. authority to exercise virement and limits applying;

5. achievement of planned levels of service; and

6. the provision of regular monitoring reports.

The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board.

Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement and an HSCP's facility to carry forward an underspend through the Local Authority's General Reserve.

The Chief Officer of an HSCP may not vire between the Integrated Budget and those budgets which are out with the scope of the Strategic Plan without Board agreement (see also Section 17: Health and Social Care Partnerships).

Where the Board's financial contribution to an HSCP for delegated functions is underspent in year the HSCP may carry the balance forward through the Local Authority's General Reserve. The exception is where an unplanned underspend arises due to material differences in the assumptions used in setting the payment to the joint board. In these cases the underspend

will be returned to the Board in year and the Board's financial contribution will be adjusted recurrently.

The Board shall contain any overspend on the non-integrated budgets within non-integrated resources. Only in exceptional circumstances shall the Board's financial contribution to the Joint Board be amended in order to redirect resources to non-integrated budgets. Any reduction must be approved by the Joint Board.

Non-recurring budgets should not be used to finance recurring expenditure without the authority in writing of the Chief Executive. The Finance and Planning Committee will oversee the use of non-recurrent funds and reserves to ensure the medium to long term sustainability of the Board.

Any person committing NHSGGC to expenditure must have authority to do so in the Scheme of Delegation. Expenditure for which no provision has been made in an approved budget and not subject to funding under the delegated powers of virement shall only be incurred after authorisation by the Chief Executive, or the Director of Finance or the Board as appropriate in accordance with the Scheme of Delegation.

2.5 BUDGETARY CONTROL AND REPORTING

The Director of Finance will devise and maintain systems of budgetary control. These will include:

1. financial reports available to the Board, in a form approved by the Board, containing:

   - income and expenditure to date showing trends and forecast year-end position;
   - movements in working capital materially affecting resource limits;
   - capital project spend and projected out-turn against plan;
   - explanations of any material variances from plan;
   - details of any corrective action where necessary;
   - an assessment of financial risk.

2. the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering areas for which they are responsible;

3. investigation and reporting of variances from financial, workload and manpower budgets;

4. monitoring of management action to correct variances; and

5. arrangements for the authorisation of in-year budget transfers.

All budget holders are accountable for their budgetary performance. Budget Holders must ensure there is available budget in place before taking any decisions in line with their delegated authority. Each budget holder is responsible for ensuring that:

1. any likely overspending or reduction of income, which cannot be met by virement, is not incurred without the prior consent as outlined in section 2.4 above;

2. the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement.

The Chief Executive is responsible for identifying and implementing efficiency and rationalisation programmes together with income initiatives in accordance with the requirements of the Financial Plan and any other guidance received from the SGHSCD from time to time and to thereby ensure a balanced budget.

Chief Officers/Directors of each Division/HSCP must ensure that these budgetary control and reporting disciplines operate in their Division/HSCP. This supports NHSGGC's overarching budgetary control environment.

2.6 MONITORING RETURNS

The Chief Executive is responsible for ensuring that the appropriate monitoring returns are submitted to the SGHSCD and any other statutory organisation as required.

2.7 CAPITAL EXPENDITURE

The general rules applying to delegation and reporting shall also apply to capital expenditure including the requirement to stay within the Capital Resource limit [CEL 19 (2009) refers [See also Section 12 of these Instructions].

2.8 SCHEME OF DELEGATION

The Board shall approve a Scheme of Delegation which will specify:

1. areas of responsibility;

2. nominated officers; and

3. the scope of the delegation in terms of financial value, time span etc.

The Scheme of Delegation will be reviewed and approved by the Board as part of the annual review of Corporate Governance arrangements.

2.9 PROJECT AUTHORISATION

A Business Case for proposed changes to existing service provision must be submitted to the Finance and Planning Committee for approval where the proposal includes major service change, major workforce change or where the revenue implications are unfunded or greater than £1.5m. The proposal must be in accordance with the Board's clinical strategy and reflect the Corporate Plan, the HSCP's Strategic Plan and the Annual Operational Plan

The Business Case should cover the following sections in sufficient detail to explain the proposal:

1. description of proposal;
2. statement of strategic fit;
3. detailed option appraisal, explanation of alternative options reviewed against a set of pre-agreed criteria and scoring summary;
4. financial appraisal, including summary of capital and revenue cost implications of alternative options;
5. overview of preferred option;
6. summary of implementation plan for preferred option with key milestones;
7. summary of benefit of preferred option;
8. risk management - plan for management of implementation and financial risks associated with preferred option; and

9. confirmation from the Head of Procurement that any preferred procurement route is compliant with procurement rules and legislation.

The sources of funding for the proposed development must be identified with confirmation from existing budget holder(s) that the funds will be available for the proposed purpose. The Director of Finance will certify that additional allocations from SGHSCD identified in the Business Case will be available for that purpose.

Where the revenue implications of a project are up to £1.5m and funded from available resources a Business Case will be submitted for approval by the Acute Strategic Management Group, the HSCP Board or the Director of Finance as appropriate.

Where an approved Business Case requires third party spend the budget owner will complete a Project Authorisation checklist which will be forwarded to the Head of Procurement or relevant Board Procurement Lead as authority to proceed to Procurement.

2.10 REGIONAL PLANNING

Regional Planning Groups simplify financial arrangements by reaching binding agreements on how regionally provided developments should be funded. The Board Chief Executive is a member of the West of Scotland Regional Planning Group and is responsible for agreeing developments on behalf of the Board. The principles adopted by the Regional Planning Group are that:

- The costs of regional services, suitably benchmarked and validated, should be agreed on behalf of member boards by the Regional Planning Grouping with Chief Executive involvement.
- The NHS Board hosting the regional service should be able to clearly demonstrate the level of costs which result from providing the regional service with independent cost audits available if appropriate.
- Costs of regional services should be divided between the participating Boards on a weighted capitation basis rather than on volume of use unless this is inappropriate or unwieldy.
- The NHS Board hosting the regional service shall charge Boards for the service through the Service Level Agreement process.

SECTION 3

ANNUAL ACCOUNTS AND REPORTS

The Director of Finance, on behalf of the Board, will:

1. keep, in such form as the Scottish Ministers may direct, account of all monies received or paid out by NHSGGC;

2. prepare financial returns in accordance with the guidance issued and regulations laid down by the Scottish Ministers, NHSGGC's accounting policies and generally accepted accounting principles;

3. prepare, certify and submit Accounts in respect of each financial year as required by Section 86 (3) of the NHS (Scotland) Act 1978;

4. ensure that Accounts are prepared in a format which meets the requirements of the Health Board Accounts Manual, recognise best accounting practice and such other legislation, directions and guidance as may be in force at the time;

5. ensure that the Accounts are produced in accordance with the timetable set down by the SGHSCD and by the Auditor General; and

6. ensure that there is evidence of compliance with NHSGGC's Corporate Governance measures in accordance with extant guidance issued by the SGHSCD.

NHSGGC's Annual Accounts must be audited by an independent External Auditor (External Audit is dealt with at greater length in Section 4 of these Instructions).

The audited Accounts must be presented to and approved by the Board at a Board meeting.

SECTION 4

AUDIT

4.1 AUDIT AND RISK COMMITTEE

In accordance with Standing Orders and as set out in guidance issued under NHS MEL (1994) 80, the Board will establish an Audit Committee. This is known as the Audit and Risk Committee.

The purpose of the Audit and Risk Committee is to assist the Board to deliver its responsibilities for the conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control and risk management is in place to ensure that:

1. business is conducted in accordance with the law and proper standards governing the NHS and its interface with partner organisations;
2. public money is safeguarded and properly accounted for;
3. financial statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question; and
4. reasonable steps are taken to prevent and detect fraud and other irregularities.

The Audit and Risk Committee will support the Board and the Accountable Officer by reviewing the comprehensiveness, reliability and integrity of assurances provided to meet the assurance needs of the Board and Accountable Officer. In this context, assurance is defined as an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework.

The Terms of Reference of the Audit and Risk Committee will be reviewed and approved annually by the Board.

Where the Audit and Risk Committee suspects there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the Committee wish to raise, the Chairman of the Audit and Risk Committee should raise the matter at a full meeting of the Board. Exceptionally, the matter may need to be referred to the SGHSCD (to the NHSS Director of Health Finance and Infrastructure in the first instance).

The Director of Finance will be responsible for ensuring that an adequate internal audit service is provided and the Audit and Risk Committee will be involved in reviewing tenders and awarding contracts when the contract for internal audit services is renewed or changed.

The Director of Finance will be responsible for arranging the resources required to carry out any review or investigation which is commissioned directly by the Audit and Risk Committee under its Terms of Reference.

4.2 EXTERNAL AUDIT

NHSGGC's Accounts must be audited by auditors appointed by the Scottish Ministers. Under the Public Finance and Accountability (Scotland) Act 2000, the Auditor General for Scotland will secure the audit of the Board's Accounts on behalf of the Scottish Ministers.

The audit will be carried out in accordance with the Audit Scotland Code of Audit Practice and such other relevant legislation, directions and guidance as may be in force at the time.

The external auditor will discharge his reporting responsibilities under the Audit Scotland Code of Audit Practice by providing the following outputs from the audit:-

1. an Audit Certificate on NHSGGC's Statement of Annual Accounts;

2. a Final Report to Board Members; and

3. Management Letters and other reports to management as required.

The Director of Finance will ensure that:-

1. the external auditors receive full co-operation in the conduct of the audit;

2. the Final Report to Board Members together with the audited Accounts are presented timeously to the Board for noting and adoption, and the adopted Accounts are subsequently forwarded to the SGHSCD; and

3. action is taken in respect of all recommendations contained in the external auditor's reports and letters in accordance with the timetable agreed with the external auditor.

The external auditor will normally be expected to attend Audit and Risk Committee meetings and has a right of access to the Chair of the Board, all Audit and Risk Committee Members and other Members of the Board. The external auditor will meet on at least one occasion each year with the Audit and Risk Committee without the Director of Finance, other Executive Directors or Board staff being present.

4.3 DIRECTOR OF FINANCE

The Director of Finance is responsible for:

1. ensuring that there are arrangements to review, evaluate and report on the effectiveness of internal financial control by the establishment of an internal audit function headed by a Chief Internal Auditor/Audit Manager of sufficient status;

2. ensuring that the internal audit service is adequate and meets NHS mandatory standards;

3. agreeing with the Directors of Finance of partner local authorities which incumbent internal audit team shall undertake the internal audit of an HSCP;

4. ensuring that responses to internal audit reports are provided timeously and that internal audit recommendations are implemented as agreed; and

5. ensuring that, in cases of fraud, the NHS Counter Fraud Service is notified without delay, in accordance with NHSGGC's Fraud Policy and the Partnership Agreement with NHS Counter Fraud Services.

The Director of Finance will ensure that cases of fraud, misappropriation or other irregularities are investigated in accordance with the Fraud Policy approved by the Board.

The Director of Finance will ensure that there is adequate communication between the external and internal auditors to avoid unnecessary overlapping of work.

4.4 INTERNAL AUDIT

The role of internal audit will be based upon the guidance contained in the Public Sector Internal Audit Standards (PSIASs). These standards are mandatory and specifically it will be the responsibility of the Chief Audit Executive/Audit Manager to review, appraise and report upon:

1. the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

2. the adequacy and application of financial and other related management controls;

3. the suitability of financial and other related management data;

4. the extent to which NHSGGC's assets and interests are accounted for and safeguarded from losses of all kinds arising from:

   (a) fraud and other offences (where malpractice is suspected, the Director of Finance should be notified immediately);

   (b) waste, extravagance and inefficient administration, poor value for money or other causes;

5. the efficient use of resources;

6. the adequacy of follow up action to their reports; and

7. post transaction monitoring of property transactions in accordance with the provisions of the NHS Property Transaction Handbook.

The Director of Finance or other officers, such as the Chief Audit Executive/Audit Manager, Fraud Liaison Officer or NHS Counter Fraud Staff acting on the Director of Finance's behalf [including staff of third parties if the internal audit service is outsourced] will be entitled, without necessarily giving prior notice, to require and receive:

1. access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature (in which case there will be a duty to safeguard that confidentiality);

2. access at all reasonable times to any premises or land of NHSGGC;

3. the production or identification by any employee of any Board cash, stores, or other property under the employee's control; and

4. explanations concerning any matter under investigation.

The Chief Audit Executive/Audit Manager will report directly to the Director of Finance, and copy all reports to him. The Director of Finance will ensure that appropriate responses are provided and action is taken in respect of all internal audit reports.

1. the timetable for completion of reports and provision of responses will be as agreed between the Chief Audit Executive/Audit Manager and the Director of Finance.

2. where, in exceptional circumstances, the use of normal reporting channels would be seen as a possible limitation of the objectivity of the audit, the Chief Audit Executive/Audit

Manager will seek the advice of the Chairman of the Audit and Risk Committee or Chairman or Vice Chairman of the Board.

3. failure to take any necessary remedial action within a reasonable period will be reported to the Chief Executive.

The Chief Audit Executive/Audit Manager will normally attend Audit and Risk Committee meetings and has a right of access to the Chairman of the Board, all Audit and Risk Committee Members and other Members of the Board. The internal auditor will meet on at least one occasion each year with the Audit and Risk Committee without the Director of Finance, other Executive Directors or Board staff being present.

The Chief Audit Executive/Audit Manager will prepare an annual audit report for consideration of the Audit and Risk Committee. The report must cover:

1. a statement on the adequacy and effectiveness of NHSGGC's internal controls based on the audit work undertaken during the year;

2. major internal control weaknesses identified;

3. progress on the implementation of internal audit recommendations; and

4. progress against the internal audit annual plan over the previous year.

The annual audit report prepared for an HSCP will be made available to the Audit and Risk Committee.

The Chief Audit Executive/Audit Manager will prepare a strategic audit plan for consideration and approval of the Audit and Risk Committee. The plan will normally cover a period of three years and will be based on an assessment of the risks facing NHSGGC. Each year the Chief Audit Executive/Audit Manager should update the plan and re-present it to the Audit and Risk Committee for approval.

The Strategic Audit Plan will be translated into an agreed Annual Plan which identifies the specific subjects to be audited in the coming year including any provision for contingencies and ad hoc work.

SECTION 5

BANKING ARRANGEMENTS

5.1 GENERAL

The Director of Finance is responsible for managing NHSGGC's banking arrangements and for advising the Board on the provision of banking services and the operation of accounts, including the levels of delegated authority.

5.2 BANKING PROCEDURES

All funds will be held in accounts in the name of NHSGGC and accounts may only be opened by the Director of Finance. Bank accounts operated by members of staff in any capacity should not be addressed to Board premises without the approval of the Director of Finance.

Only authorised signatories may draw on these accounts. The Director of Finance will approve and maintain a list of authorised signatories for this purpose.

All transactions relating to Board business must be reflected through these accounts.

The use of Board funds for making personal loans or for cashing personal cheques is not permitted.

The Director of Finance is responsible for:

1. establishing bank accounts;

2. establishing separate bank accounts for NHSGGC's non-exchequer funds;

3. defining the use of each account; and

4. ensuring that payments made from bank accounts do not exceed the amount credited to the account except as detailed in section 5.3 below.

The Director of Finance will ensure that detailed written instructions on the operation of bank accounts will include:

1. the conditions under which each bank account is to be operated;

2. a list of those authorised to sign cheques or other orders drawn on NHSGGC's accounts, including specimen signatures and the level of authority delegated to each signatory;

3. a list of those authorised to authenticate electronic payments.

The Director of Finance must advise NHSGGC's bankers in writing of the conditions under which each bank account is to be operated. This will include a list of authorised signatories with specimen signatures and the level of authority delegated to each.

The Director of Finance will advise NHSGGC's bankers of the conditions under which any on-line banking service to which NHSGGC subscribes is to be operated, including lists of those authorised to approve transfers between accounts and BACS payments to other bodies, together with levels of authority.

5.3 BANK ACCOUNTS

The balances of accounts holding exchequer funds should not exceed any limits that may be set, from time to time, by the SGHSCD. All surplus funds must be maintained in accordance with the banking guidelines issued by SGHSCD.

Bank accounts will not be permitted to be overdrawn, pooling arrangements on bank accounts maintained in the same name and in the same right notwithstanding.

5.4 TENDERING AND REVIEW

The Director of Finance will review the banking arrangements of NHSGGC at regular intervals to ensure they reflect best practice and represent best value for money.

Banking services will be subject to the procurement procedures set out in Section 10 of these Instructions.

SECTION 6

INCOME, SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 INCOME SYSTEMS

The Director of Finance is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

All staff charged with the responsibility of administering monies have a duty to ensure that these funds are safeguarded and that any monies received are banked promptly.

6.2 INCOME FROM EXTERNAL BODIES

Where services are provided to external bodies, and the fees or charges are not determined by SGHSCD or by Statute, those responsible for that service must ensure that an appropriate charge is made which recovers all relevant overheads. These charges should be reviewed annually. Independent professional advice on matters of valuation will be taken as necessary.

Employees entering into arrangements whereby fees are charged to, or income received from, a third party must inform the relevant senior financial officer who will advise on an appropriate level of fee and authorise the arrangement. The relevant senior financial officers are:-

Board:
a) the Director of Finance
b) the Assistant Director of Finance – Corporate Services and HSCPs
c) the Assistant Director of Finance - Financial Services

Acute:
a) the Director of Finance
b) the Assistant Director of Finance – Acute Services
c) the Directorate Heads of Finance

HSCPs:
a) the Director of Finance
b) the Assistant Director of Finance – Corporate Services and HSCPs
c) the Chief Financial Officer - HSCPs

Fees may be waived only on the authority of one of the aforementioned.

NHS Scotland Central Legal Office advice should be obtained in relation to non standard contracts and agreements. Prior approval will be required prior to obtaining such advice.

Departments must maintain a register of all such contracts and agreements. The register will be reviewed by the relevant Head of Finance or Chief Financial Officer annually.

Intellectual Property and any income generated will be managed in accordance with NHS MEL (1998) 23, the Policy Framework for managing Intellectual Property in the NHS arising from Research and Development and HDL (2004) 09, Management of Intellectual Property in the NHS.

6.3 GRANTS AWARDED BY OTHER PARTIES

Where a grant is awarded to NHSGGC by a third party in respect of a specific project or piece of work, the Director of the department receiving the grant should discuss with the Director of Finance the accounting arrangements and any requirement for the grant to be audited.

6.4 DEBT RECOVERY

The Director of Finance is responsible for ensuring that appropriate recovery action on all outstanding debts is taken.

Income not received/bad debts should only be written-off with the appropriate authority and dealt with in accordance with the losses procedures detailed in section 18 “Fraud, Losses and Legal Claims”.

Systems should be put in place to prevent overpayments, but where they do occur, overpayments should be detected and recovery initiated. Write-off of unrecovered amounts is also covered in section 18, as referred to above,

6.5 SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

The Director of Finance is responsible for ensuring:

1. the approval of the form of all receipt books, agreement forms, or other means of officially acknowledging or recording monies received or receivable;

2. the appropriate ordering and secure control of any such stationery; and

3. that systems and procedures for handling cash and negotiable securities on behalf of NHSGGC are in place;

In addition the Director of Estates and Facilities is responsible for ensuring:

1. the provision of adequate facilities and systems for employees whose duties include collecting and holding of cash, including the provision of safes or lockable cash boxes, the procedures for keys, and for coin operated machines; and

2. that a system for the transportation of cash is in place.

The use of Board funds for making personal loans or for cashing personal cheques is not permitted.

Cash balances held on NHSGGC premises will be kept to the minimum required for the provision of NHSGGC services. Where there is any significant increase in the level of funds held (either official or unofficial), the approval of the relevant Chief Officer must be obtained.

All cheques, cash and other negotiable instruments should be banked intact promptly, to the credit of the prescribed income or debtors account. The makeup of cash banked may be altered where change is required by the site provided the total amount of cash banked is unchanged. Cheques may not be substituted for cash and disbursements may not be made from cash received.

The holders of safe keys should not accept unofficial funds for depositing in their safes.

Keys should be held on the keyholder’s person or kept secure at all times. Keys should not be kept in, or on, desks (either hidden or otherwise). A spare key should be held off-site by a senior manager for instances where the keyholder has an unplanned absence. The senior manager will take adequate precautions surrounding the security of the spare key and will keep a record of any instances where it is issued.

During the absence (e.g. on holiday) of the holder of a safe or cash box key, the officer who acts in their place is subject to the same controls as the normal holder of the key. There should be a written discharge for the safe and/or cash box contents on the transfer of responsibilities and the handover certificate must be retained for inspection.

Any loss or shortfall of cash, cheques, or other negotiable instruments, however occasioned, shall be reported immediately in accordance with the agreed procedure for reporting losses (see SFI 18 – Fraud, Losses and Legal Claims).

SECTION 7

HEALTHCARE SERVICE PROVISION

7.1 INTRODUCTION

The Board will approve, within the context of the HSCP Strategic Plans and the Annual Operational Plan, the particular arrangements for healthcare services for the population on an annual basis. The Chief Executive is responsible for ensuring that

1. appropriate agreements are in place with healthcare service providers (both within and out-with the NHS); and

2. agreements for healthcare are made with due regard to the guidance on planning and priorities issued by the SGHSCD, as well as the need to achieve value for money and to minimise risk. Agreements must ensure that the agreed activity levels are appropriate in terms of the demand for services and NHSGGC's allocation.

Appropriate agreements should be in place for:

1. the provision of healthcare services to NHSGGC by other NHS bodies and by bodies out-with the NHS; and

2. the provision of healthcare services to other NHS bodies by the Board.

The Director of Public Health, in their capacity as the Board's Caldicott Guardian, will ensure that all systems operate in such a way as to maintain patient confidentiality in terms of the Data Protection Regulations and Caldicott guidance.

NHS Bodies
Where the healthcare services are provided to NHSGGC by another NHS Board, or where healthcare services are provided to another NHS body by NHSGGC, a Service Level Agreement (SLA) should be prepared specifying the level of activity expected of the provider and defining the funding arrangements.

In addition, the Director of Finance will ensure that:

1. there is a monitoring system in place to ensure the payment is related to satisfactory delivery of the required service, value for money is achieved and risks to the Board are eliminated or reduced ;

2. the total value of healthcare agreements placed are within the resources available to NHSGGC; and

3. procedures are in place for the handling of charges in respect of Unplanned Activity Contracts (UNPAC's) and Out of Area Placements (OAP's) in accordance with the guidance issued by the SGHSCD.

Non-NHS Organisations
Where services are provided by non-NHS organisations, the guidelines in Section 9, Non-pay Expenditure and Section 10, Orders, Quotations and Tenders should be followed.

7.2 VOLUNTARY SECTOR ORGANISATIONS AND GRANT FUNDING

Where the Board requires a specific service and/or specifies how that service will be delivered, grant funding is inappropriate and the service should be procured following the guidance in Section 9, Non-pay Expenditure and Section 10, Orders, Quotations and Tenders. Grant funding should not be used to deliver the Board's statutory obligations.

A Waiver to Tender should be completed for all grant awards and signed by the relevant Director/Chief Officer. This should then be signed by the Head of Procurement who will arrange to issue a Condition of Grant Letter.

Where a grant is awarded by NHSGGC to a third party the Condition of Grant Letter formalises the arrangements for the award of funding. Formal offers of funding should be conditional on the acceptance of formal terms and conditions including:

- a requirement to demonstrate that funds have been spent on authorised activities; and
- clawback provisions.

As NHSGGC is a public body we must consider whether any funding which the Board provides may fall within the definition of State aid. Although responsibility for a breach of the State aid regulations lies with the recipient, and the recipient will be fined if the Board does not recover the funding, there is a reputational risk to the Board. There may also be financial consequences for the Board if a project has to be stopped and money clawed back.

To fall within the definition of State aid the recipient must be engaged in a commercial activity and gain a competitive advantage over others.

7.3 GRANTS AWARDED TO NHSGGC BY OTHER PARTIES

Refer to Section 6 for grants awarded to NHSGGC by other parties.

7.4 JOINT FUNDING

Where a project is to be jointly funded each partner will agree their level of contribution in advance.

Where the Board is the lead partner responsible for commissioning a service and monitoring delivery the procurement process will be undertaken in accordance with Section 10 – Orders, Quotations and Tenders.

SECTION 8

PAY EXPENDITURE

8.1 REMUNERATION

The Board will establish a NHSGGC Staff Governance Committee whose composition and remit will be approved by the Board.

The NHSGGC Staff Governance Committee will establish a Remuneration Sub Committee to consider the remuneration of the senior managers on the Executive Pay Arrangements within the NHSGGC area, to ensure consistent application of the methods of objective setting, appraisal of performance and remuneration decisions.

NHSGGC will remunerate the Chair and Non-executive Directors in accordance with the instructions issued by Scottish Ministers.

8.2 STAFF APPOINTMENTS, CHANGES AND TERMINATIONS

Directors or employees authorised to do so may engage, re-engage or regrade employees, or hire agency staff, only within the limit of their approved budget and financial establishment. All appointments must be in accordance with approved Human Resources and Staff Governance Policies. In order to comply with the Board's Code of Conduct staff members should take no part in the appointment of family and friends and should declare any such interests to their line manager.

All appointment forms should be sent to the eESS Support Team for processing. Managers must ensure that terminations and changes are processed using the eESS Manager Self Service system. It is essential that a termination is processed immediately upon the effective date of an employee's resignation, retirement or termination being known. Where an employee fails to report for duty in circumstances that suggest that they have left without notice, the Payroll Department must be informed immediately.

Where contractors are used (as opposed to directly employed staff), any contract awarded must demonstrate value for money and comply with procurement procedure in respect of SFI's on Orders, Quotations and Tenders. For the avoidance of doubt, the value to be considered, in this respect, is the total value of payments over the duration of the contract.

8.3 PROCESSING OF PAYROLL

The Director of Finance is responsible for ensuring:

1. that appropriate payroll services are provided to meet NHSGGC's needs;

2. that there are appropriate operating policies and procedures in place to control all pay expenditure;

3. that appropriate authority to approve pay expenditure and changes is embedded within the eESS system; and

4. that only approved time records, pay sheets and other pay records and notifications are used.

Regardless of the arrangements for providing the payroll service, the Director of Finance will ensure that the chosen method is supported by appropriate management arrangements, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to the appropriate bodies.

8.4 PROCESSING OF EXPENSES

The Director of Finance will ensure that all expenses claimed by employees of NHSGGC or outside parties are reimbursed in line with the relevant regulations. Claim forms for expenses will be in an approved format, and will be completed and authorised by an officer approved by the Director of Finance. Such forms will be accompanied by supporting vouchers (or supporting vouchers will be forwarded where claims are submitted electronically). These will be submitted timeously and/or in accordance with the agreed timetable.

8.5 AUTHORISATION

All payments to staff will be subject to authorisation by a budget holder or other officer with delegated authority to approve payroll expenditure in that area. Such authorisation should be based on adequate review and, where reliance is placed on the work of others to carry out this review, must, as a minimum, include a specific review of any entries relating to officers whose work is being relied on.

Wherever possible, officers should not compile their own payroll input. Where it is unavoidable that the compiler of the payroll input is included on that input, then the entry in respect of the compiler must be initialled by the authorising officer.

Under no circumstance should officers authorise/approve their own payroll input or expenses.

Where overtime is to be paid, the authorising officer must ensure that it has been properly approved by the budget holder in advance and that they are satisfied that the additional time has been worked and is in addition to the staff member's normal duties.

Once authorised, all payroll documents should be submitted directly to the Payroll department by the authorising officer. If this task is delegated, then steps should be taken to ensure that there are no amendments made following authorisation.

8.6 RESPONSIBILITIES OF EMPLOYEES

All staff have a responsibility to check their payslip in order to ensure that they are being paid correctly. If an employee believes that they are being paid incorrectly – either being underpaid or overpaid – they should report the matter to their line manager or alternatively to the Pay Department using the contact information contained on their payslip. A failure to check that salary is being paid correctly will not in itself provide an employee with justification for refusing to repay any amount overpaid.

8.7 CONTRACT OF EMPLOYMENT

The Director of Human Resources and Organisational Development is responsible for;

1. ensuring that all employees are issued with a Contract of Employment in a form approved by the Board and which complies with employment legislation; and

2. ensuring that variations to, or termination of, contracts of employment are dealt with by the appropriate officer, in line with the procedure in place for such instances.

SECTION 9

NON-PAY EXPENDITURE

9.1 INTRODUCTION

All non-pay expenditure will be authorised, purchased and paid in accordance with these Standing Financial Instructions and the Board's Scheme of Delegation, ensuring that NHSGGC achieves financial balance, procures best value for money goods and services, meets commercial best practice and complies with European and UK competition legislation.

9.2 STAFF RESPONSIBILITIES

The Director of Finance will ensure that:

1. all accounts and claims are properly paid;

2. the Board is advised on the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained;

3. these thresholds are regularly reviewed; and

4. that NHSGGC has a Construction Procurement Policy that is consistent with national policy and guidelines.

The Head of Procurement is responsible for ensuring the preparation, maintenance and issue of procedural instructions on the procurement of goods, works and services incorporating these thresholds;

All non medicine procurements will be administered by the Procurement Department unless specific delegated purchasing authority has been granted by the Chief Executive. In some cases Procurement delegates purchase order responsibility to other "expert" departments (Medical Physics, Catering, Laboratories and eHealth), whilst maintaining overall responsibility for commercial arrangements.

The Director of Pharmacy will be responsible for the ordering of, the safe storage and distribution of medicines in accordance with the Human Medicines Regulations 2012.

There must normally be segregation of duties between the activities of requisitioning, order approval, receipting and paying of goods and services. Exceptions are where:-

- a requisitioner's access permissions within PECOS are restricted by value, or, to specific catalogue items or suppliers. In this case a purchase order will be automatically generated by the system;
- where an order is placed with the National Distribution Centre it is regarded as a stock issue with no requirement for separate receipting of the goods;
- desktop delivery orders will be automatically marked as not eligible for receipt by the system.

The Director of Finance and Head of Procurement will ensure that appropriate segregation is in place at all times.

All officers must comply with the Code of Conduct for Staff and register any personal interest. Where an officer has an interest which relates, directly or indirectly, to any proposed purchase or contract, they must not take part in any aspect of the purchasing and procurement processes for that purchase or contract.

Any officer who is involved in any part of the contracting or purchasing process is responsible, as far as they are able, for ensuring that NHSGGC is only committed to contracts or purchases which are in accordance with NHSGGC's policies and which give NHSGGC maximum value for money when compared with any known alternatives.

No staff should make a binding commitment on behalf of NHSGGC unless they have the delegated authority to do so. Any authorised commitments must be in writing. Staff should be aware that the terms of the Requirements of Writing (Scotland) Act 1995 states that NHSGGC can be bound by a verbal undertaking given by an officer of NHSGGC in the course of business.

9.3 NON-PAY EXPENDITURE APPROVAL PROCESS

Budgetary Control

No order will be placed or contract let for goods or services where there is no budget provision, unless authorised by the Director of Finance or the Chief Executive.

Contracts or orders will not be placed in a manner devised to avoid the financial limits specified by the Board.

Tendering and Quotations

All contracts and purchases will be tendered in accordance with SFI10 “Orders, Quotations and Tenders”, with the objective of securing goods and/or services of the necessary quality and quantity in accordance with NHSGGC's objectives and strategies at the most economic rates. All procurements must be carried out in accordance with all relevant National and EU regulations, directives and guidelines.

The Public Contracts (Scotland) Regulations are applicable to all public sector organisations. These regulations are prescriptive in their requirements for public sector organisations and these SFI’s are designed to ensure NHSGGC's full compliance.

The Freedom of Information (Scotland) Act 2002 (and any subsequent amendments) is applicable to public sector procurements where specific provisions and requirements with regard to disclosure of information apply and may override commercial sensitivities in some circumstances if deemed in the public interest. Given the potential for commercial prejudice therefore, and the risks to NHSGGC associated with compliance or non-compliance with the FOI Act, a structured and disciplined tender and contract award process taking into account FOI requirements shall apply in most circumstances. These SFIs set out appropriate responsibilities for designated officers with external commitment authority, who in turn shall ensure that tender and contract award processes meet the provisions and requirements of this regulation.

The Equality Act 2010 outlaws any discrimination, including any potential discrimination through the provision of goods and services. All public authorities therefore have a duty to take equality into account when procuring goods, works, or services from external providers. These SFI’s set out appropriate responsibilities for designated officers with external commitment authority, who in turn shall ensure that tender and contract award processes meet the legal provisions and requirements and that suppliers and contractors adhere to the equality and diversity legislation and principles.

Contracts

By definition a contract is any agreement between NHSGGC and other party/parties that is enforceable by the law. Contracts can be formed orally, in writing or even by conduct.

Where national, regional or local contracts exist (including framework agreements) the overriding principle is that use of these contracts is mandatory. Only in exceptional circumstances and with the authority of the Head of Procurement or the Director of Finance shall goods or services be ordered out-with such contracts. The Head of Procurement will maintain a record of any contracts placed out-with such contracts.

All contracts will have a sound basis in law and appropriate commercial contract conditions must be chosen to minimise the risk of any adverse litigation. Where appropriate, National Standard Forms will be used and where contracts are not of a standard form, the Central Legal Office should be consulted. Note that prior approval will be required prior to consulting CLO.

All non standard form contracts shall be approved and issued only by the Head of Procurement unless specific delegated authority has been granted by the Chief Executive or the Board.

Purchase Indents

Prior to any Official Order being raised a purchase indent must be submitted and approved in accordance with the Scheme of Delegation.

Authorisation

All indents and associated orders for the purchase of items must be properly authorised in accordance with these SFI's. The ordering/authorising officer is responsible for satisfying himself that NHSGGC's contracting and ordering instructions have been properly complied with before they sign an order and that the order does not commit NHSGGC to expenditure in excess of the budgeted amount.

The Director of Finance has responsibility, acting on behalf of the Chief Executive, for the setting of financial limits as defined in the Scheme of Delegation.

Delegation of Authority

The Board will approve the level of non-pay expenditure on an annual basis and the Chief Executive will determine the level of delegation to budget managers.

Each operating unit will maintain a Scheme of Delegation and all employees must comply with the limits set in all aspects of non-pay expenditure. The Head of Financial Governance will be responsible for ensuring that schemes are consistent. Delegated limits will be reviewed annually by the relevant Head of Finance/Chief Financial Officer.

Indents/Requisitions for supplies can only be authorised by the budget holder of the directorate or department (or someone formally delegated with that authority) where the expenditure is planned and covered by available funds. The Director of Finance will ensure that there is a list of authorised signatories maintained for this purpose. Such delegated authority will be embedded in any electronic purchasing systems.

Purchase Orders

Only NHSGGC's authorised ordering officers, as approved by the Director of Estates and Facilities, shall sign purchase orders. This includes authorised ordering officers where Procurement has delegated authority to other "expert" departments (section 9.2).

No goods or services may be ordered without the use of NHSGGC's official order form, including electronic versions. No officer of NHSGGC is permitted to make commitments out-with the official indenting and ordering processes unless the goods or services being procured

have been generally or specifically exempted from these processes by the Chief Executive or Director of Finance.

The Head of Procurement will be responsible for ensuring that suppliers are made aware of the official ordering process.

Construction Procurement

All construction procurement will be made in accordance with SGHSCD guidance and NHSGGC's Construction Procurement policy.

Trial/Loan Products

Products e.g. medical equipment, shall not be taken on trial or loan from suppliers or contractors unless authorised in accordance with these SFI's and the Scheme of Delegation and/or approved by the appropriate procurement department to ensure any arrangements are consistent with purchasing policy and do not commit the Board to a future uncompetitive purchase. The Board's Code of Conduct should be followed in these instances.

9.4 PAYMENT OF ACCOUNTS

The Director of Finance will ensure that there are adequate systems and procedural instructions covering the procurement process and the procedures for the verification, recording and payment of accounts and claims payable. These procedures will ensure that:

1. properly authorised accounts and claims are paid promptly in accordance with the terms of the Late Payment of Commercial Debt (Interest) Act 1998 (and any subsequent amendments) and payment of contract invoices is in accordance with contract terms, or otherwise in accordance with national guidance;

2. payment shall only be made for goods and services that have a corresponding official purchase order; and

3. payment for goods and services is only made when goods and services are received and accepted (excepting exceptional circumstances).

Specifically the system will include checks that:

1. goods received are in accordance with those ordered and that prices are correct or within tolerances approved by the Director of Finance.

2. work done or services rendered have been carried out satisfactorily and are in accordance with the order and the agreed contract terms.

3. in the case of contracts for measured time, materials or expenses, time is verified, rates are in accordance with those quoted, and materials or expenses are verified for quantity, quality and price.

4. expenditure is in accordance with regulations and authorisations.

5. the account is arithmetically correct.

6. VAT and other taxation is recovered where permitted by legislation.

7. the account is in order for payment.

Payments should not normally be made in advance of need i.e. before the liability to pay has matured. However, there may be certain exceptional circumstances where it is in NHSGGC's interests to make such a payment. Under no circumstances should any advance payment be made where there is a risk to public funds.

The approval of the Director of Finance is required in any instances where payment for goods or services in advance is deemed to be required.

Where a manager certifying accounts relies upon other managers to do preliminary checking, they shall ensure that those officers are competent to do so and, wherever possible, ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms.

In the case of contracts for building or engineering works that require payment to be made on account during progress of the works, NHSGGC will make payment based on receipt of a certificate from the appropriate technical consultant or manager. Certificates will be subject to such examination as may be considered necessary before authorisation by the Director of Estates and Facilities (or other Director responsible) or their nominated deputy.

The Director of Finance may authorise advances on an imprest system for petty cash and other purposes as required. Individual payments must be restricted to the amounts authorised by the Director of Finance and must only be used for purposes where it is not appropriate to use the normal payment or payroll systems.

SECTION 10

ORDERS, QUOTATIONS AND TENDERS

10.1 BUDGET PROVISION

No order will be placed or contract let for goods or services where there is no provision in the Financial Plan unless authorised by the Director of Finance or the Chief Executive. Where contracts cover periods falling out-with the current financial year budget provision is deemed to mean recurring budget.

10.2 SPECIFICATION OF NEED

All contracts will have a formal specification of need developed in conjunction with NHSGGC expert users. The Board Procurement Leads will provide best practice advice and guidance in the development of the specifications. Approval of the specifications for externally sourced products or services requirements and the approval of charges against specified budgets for all externally purchased products or services shall be the responsibility of budget holders and limits on budget holder's individual approval levels shall be specified in the Scheme of Delegation.

Budget holder approval of specifications for certain externally supplied products or services shall be delegated to Clinical Heads of Service or Managers of designated specialist support departments. Clinical Heads of Service or designated specialist support managers will be responsible for providing specification criteria under national contract, where required, and for ensuring that products meet required specifications.

Pre market engagement with suppliers and expert bodies may be undertaken to seek advice in the planning and conduct of the procurement procedure however care must be taken to ensure such contact does not distort competition or violate the principles of transparency and non-discrimination.

Budget holders' approval of charges against specified budgets for externally purchased products or services may also be delegated to nominated Project or other Health Board executive or senior managers as specified in Capital or Revenue budget setting and approval processes.

10.3 OFFICIAL ORDERS

No goods, services or works, other than purchases from petty cash, purchase cards or where particular supplies have been exempted by the Chief Executive or Director of Finance, will be ordered, except on an official order, and contractors will be notified that they should not accept orders unless on an official form.

The Head of Procurement will prescribe standard conditions of contract appropriate to each class of supplies and services and for the execution of all works. All contracts and orders entered into will incorporate these conditions.

10.4 ORDERING PROCEDURE

Official orders will be generated by the Board's electronic procurement system, in a form approved by the Head of Procurement and shall include information concerning prices or costs as they may require. The order shall incorporate an obligation on the supplier or

contractor to comply with the Board's conditions of contract detailed on the website as regards delivery, carriage, documentation, variations etc.

Orders/requisitions shall only be authorised by those officers specified within the Scheme of Delegation. A database of authorised officers shall be maintained and made available to the Director of Finance on request.

Only Post Holders delegated by the Board shall be authorised to commit NHSGGC to commitments with external parties. The Post Holders limit of authority is defined by the Scheme of Delegation.

Orders shall not be placed in a manner devised to avoid the financial thresholds specified in this Instruction.

10.5 CONTRACTS

The current Public Contracts (Scotland) Regulations place additional duties on Public Bodies in Scotland. They are mandatory and must be adhered to. Contracts for goods and services above £50,000 (£2m for works) are designated as Regulated Procurements and the Procurement Reform (Scotland) Act 2014 sets out specific requirements which must be adhered to by the Board. All proposed contracts must be discussed at the earliest stage of planning with one of the Board's procurement service providers to ensure the requirements of the Act are met.

The EU Regulations on State Aid must also be considered to ensure compliance with current EU requirements.

Where supplies and services of the type and quantity required are available on National, Regional or Local Contract, the order must be placed with a supplier designated in that contract. Only in exceptional circumstances and only with the authority of the Director of Estates and Facilities shall supplies and services available on contract be ordered out-with contract. Such exception will be recorded and reported to the Director of Finance. Use should also be made of other UK Public Sector available contracts where they provide best value of money.

Where approved Contracts exist for the same product or services, with more than one supplier, then the contracted supplier offering best value for money must be selected.

For works projects, tender lists will be compiled in accordance with requirements issued by the Scottish Government and utilising industry schemes for pre-tender company checks.

Where a framework contract exists (either nationally or locally), this contract must be used. Where a sole supplier or multi supplier ranked framework is available the contract would be awarded to the sole supplier or awarded in order of ranking. A Waiver to Tender is not required in these circumstances as a tender has already taken place however where a contract is not placed with the first ranked supplier a standard award report should specify the rationale. Where there is a multi supplier unranked framework the terms and conditions of the Framework Call Off mechanism must be complied with and a Call Off Award Report completed to show how best value for money is achieved.

10.6 TRANSACTIONS INVOLVING PROPERTY

All transactions involving property will be conducted in accordance with the procedures set out in the NHS Property Transaction Handbook and SFI 12 Capital Expenditure.

10.7 QUOTATIONS

Where the supply of goods or services is estimated to be less than £50,000, the following applies, subject to the provisions of sections 10.8 and 10.9 (the limits quoted are exclusive of VAT where it is recoverable, and inclusive if VAT where it is irrecoverable).

- **Expenditure less than £10,000**: The ordering officer must be able to demonstrate that value for money is being obtained and will be supported in doing so by the relevant Board Procurement Lead.

- **Expenditure more than £10,000 but less than £50,000:** At least three competitive quotations shall be obtained from different companies. Quotations must be in writing and retained for inspection. For complex or higher value items a specification should be prepared as appropriate.

Where quotes are obtained on the basis that the value of the supply was genuinely believed to be less than £50,000, but satisfactory quotes are returned marginally in excess of this amount, then the purchase may proceed subject to the completion of a waiver to tender form. In cases where it is anticipated that the cost may exceed £50,000, then formal tenders should be sought in accordance with section 10.8.

10.8 COMPETITIVE TENDERING

Where the supply of goods or services is estimated to be **£50,000** or above, the following applies except where other arrangements have been previously approved by the Head of Procurement. (The limits quoted are exclusive of VAT where it is recoverable, and inclusive of VAT where it is irrecoverable.)

Competitive tenders, which must have a formal specification, will be invited for the supply of all goods and services; building and engineering or works of construction and maintenance. There must a minimum of three tenders invited in each case and a minimum of two offers received in each case (see 10.9.5). All tendering documentation must be retained and filed for inspection.

The process for tendering is stated at 10.10 below. The Public Contracts (Scotland) Regulations and EU Directives must be adhered to where contract values are expected to exceed the defined thresholds. Electronic tendering processes must be used except where approved in advance by the Director of Finance or authorised nominee.

The procurement of goods and services will not be sub divided into smaller lots in order to circumvent the requirement to obtain competitive quotations or tenders. Contract values apply to the full life of the contract rather than the annual value.

10.9 WAIVING OF TENDER/QUOTATION PROCEDURE

In the following exceptional circumstances, except in cases where EU Directives must be adhered to, a Director, as specified in the Scheme of Delegation, can approve the waiving of the above requirements:

1. where the repair of a particular item of equipment can only be carried out by the manufacturer;
2. where the supply is for goods or services of a special nature or character in respect of which it is not possible or desirable to obtain competitive quotations or tenders;
3. a contractor's special knowledge is required;

4. where the Chief Executive or the Director of Finance has approved negotiation with a single tenderer; this must be evidenced in writing;
5. where the number of potential suppliers is limited, and it is not possible to invite the required number of quotations or tenders to comply with these SFI's;
6. where, on the grounds of urgency, or in an emergency, it is necessary that an essential service is maintained or where a delay in carrying out repairs would result in further expense to NHSGGC.

Where goods and services are supplied on this basis, and the value exceeds £10,000, a "Waiver of Tender/Quotation" form should be completed, and signed by the appropriate director and the Head of Procurement (the Director of Pharmacy for the supply of medicines).

Where a Waiver to Tender is required on the basis of urgency the form must be approved by the Head of Procurement (Director of Pharmacy for supply of medicines) with a retrospective review by the Director of Finance.

Where a tender process is not possible due to a lack of competition the waiver must be signed by the Head of Procurement (Director of Pharmacy for supply of medicines) and submitted for Director of Finance approval if over £250k.

Where there has been no attempt to follow a tender process and a Waiver is completed retrospectively. Director of Finance approval is required if over £50k.

In the case of 1, 2, 3, 4 and 5 above, the Waiver of Tender/Quotation must be completed in advance of the order being placed, but may be completed retrospectively in the case of 6. The Head of Procurement will maintain a record of all such exceptions.

A Waiver is not required where a tender has been undertaken but the required number of responses has not been received. In these circumstances details should be included in the tender award report.

Where additional works, services or supplies have become necessary and a change of supplier/contractor would not be practicable (for economic, technical or interoperability reasons) or would involve substantial inconvenience and/or duplication of cost an existing contractor may be asked to undertake additional works providing the additional works do not exceed 50% of the original contract value and are provided at a value for money cost which should normally be at an equivalent or improved rate to the original contract.

When goods or services are being procured for which quotations or tenders are not required and for which no contract exists, it will be necessary to demonstrate that value for money is being obtained. Written notes/documentation to support the case, signed by the responsible Budget Holder, must be retained for audit inspection.

10.10 TENDERING PROCEDURE

Advertising

NHSGGC requires adequate advertising of future requirements for goods and services as follows:

1. all supplies covered by the EU Public Procurement legislation will be advertised in accordance with the requirements of that legislation and of the EU Public Procurement directive (2014/24/EU).

2. all other supplies which have an aggregated contract / order value of greater than £50,000 shall be advertised on the Public Contracts Scotland (PCS) internet site a minimum of 2 weeks ahead of drawing up tender lists. In exceptional circumstances the Head of Procurement or authorised nominee can waive the requirement.

3. for all requirements for 'Products and Services' with an annual or contract term value in excess of the threshold prescribed by the EU, the requirement shall also be submitted electronically in the required format for Advertisement in the OJEU Journal in accordance with the regulated timescales and procedures.

Selection of Tenderers

Tenderers will be selected based on their ability to meet minimum qualification criteria. This shall normally include financial standing, technical competence and operational capability. Where a tenderer is unsuccessful at PQQ stage the Head of Procurement or his nominated representative will provide a written debrief.

NHSGGC shall not charge tenderers a fee to submit a bid.

Issue of Tender Documents

All tender documents shall be sent to prospective suppliers with return labels issued by NHSGGC which will be addressed to the Head of Procurement or their nominated representative as appropriate and shall be marked "Tender for .....(title of tender)" but shall not bear the name or identity of the sender. Suppliers will also be issued with comprehensive instructions regarding the return of the documents. These instructions shall specifically forbid the supplier from marking the tender envelopes in a manner that indicates the sender or from associating the tender envelope with any related bill of quantity.

The Head of Procurement or authorised nominee will be notified of any tender documents issued along with the closing date and time for opening the tenders.

The Register of Tenders

A Register of Tenders will be kept in a sequentially numbered bound tender receipt book. The tender receipt book will be considered controlled stationery under the control of the Head of Procurement, or authorised nominee, who will issue to staff authorised to receive tenders on behalf of NHSGGC and record such issues.

The following details should, as a minimum, be recorded in the Register of Tenders:

1. details of the subject of the tender
2. closing date and time of receipts
3. date and time of opening of tenders with reasons for any differences from closing date and time
4. tender references sufficient to trace details of invitation to tender or details of open tender
5. amounts
6. names and signatures of the Head of Procurement's representatives and
7. Independent witness.

Receipt and Safe Custody of Tenders

Tender envelopes shall be stamped and held unopened in a secure container until after the closing date or time. A register of tenders received will be maintained at the point of receipt. This will record the date and time of receipt and also the contract that the tender relates to.

An identifying reference will be written on the envelope and entered in the register.

Tenders will be opened, as soon as possible after the stated closing date and time, by the Head of Procurement or their nominated representative, in the presence of an independent witness of senior status. Both parties will initial each tender document opened.

All relevant details of tenders received, including the tendered cost, where specified will be entered in the Register of Tenders which shall be signed by the Head of Procurement or their nominated representative and the independent witness.

Where it is clearly in the interests of NHSGGC, late, amended, incomplete or qualified tenders may be considered. In such circumstances, a full report should be made to the Chief Executive or authorised nominee, who will have authority to admit such tenders. Where a company invited to tender requests a delay in the submission, any deferment approved shall be notified to all the companies concerned.

The Head of Procurement or their authorised nominee will be notified of the date and time of all meetings arranged for the purpose of adjudicating tenders.

The Director of Finance has the right to inspect records of tenders to be received at any time in order that an auditor and/or a member of the Finance Department may attend the opening. The Director of Finance or their representative is not required to give any notice of attendance at tender openings.

Tender Acceptance

Where competitive tenders have been obtained, the most economically advantageous shall normally be accepted. A written report must be produced on the circumstances of the decision, and submitted to the Head of Procurement or authorised nominee.

Any 'in-house' bids must be submitted and evaluated on exactly the same basis as bids from out-with NHSGGC.

Stand Still Period

There must be a stand still period of 10 calendar days prior to issuing a formal contract award. This is a requirement for all EU tenders and is best practice for others. Exceptions must be approved by the Head of Procurement.

Form of Contract Award

Dependent on the nature of the procurement, an official order and/or a letter of acceptance should be issued for every contract resulting from an invitation to tender. Unsuccessful tenderers will be notified in writing together with a written debrief by the Head of Procurement or their nominated representative. Contract awards shall be published on the Public Contract Scotland (PCS) website and in OJEU where required by EU directives.

10.11 CONTRACT REGISTER / RECORDS

The head of the relevant Board Procurement Lead's department or their authorised nominee shall maintain a register of all contracts awarded by virtue of the circumstances detailed at sections 10.8 and 10.9 above. Such a register shall be open to audit on an annual basis under the direction of the Director of Finance or Chief Executive.

Retained files, of all authorised requisitions, purchase orders and contracts, either in paper or in electronic form shall be kept by each designated procurement department in accordance with audit and HMRC requirements.

10.12 CODE OF CONDUCT FOR STAFF

The Code of Conduct for Staff, which includes the circular - Standards of Business Conduct for NHS Staff, has specific guidance on the acceptance of gifts and hospitality in relation to NHSGGC's commercial dealings. This Code has been incorporated into the contract of

employment of each member of staff. A copy of the relevant NHS Circular should be enclosed with each employee's contract of employment.

The Standards of Business Conduct state that "It is a long established principle that public sector bodies which include the NHS, must be impartial and honest in the conduct of their business and that their employees must remain beyond suspicion". The Bribery Act 2010 makes it an offence to:

1. Offer, promise or give a bribe or
2. Request, agree to receive or accept a bribe,

in return for improperly performing a function or activity.

Suppliers should be made aware of the Standards of Business Conduct which apply to NHS staff and not attempt to contravene these standards.

SECTION 11

MANAGEMENT AND CONTROL OF STOCK

The Head of Procurement is responsible for the control of stores, except for:

1. pharmaceutical stock, which is the responsibility of the Head of Pharmacy and Prescribing Support Unit ; and

2. laboratories, radiography, occupational therapy and IM&T equipment, which are the responsibility of the senior manager in each of those departments.

The Head of Procurement will ensure that there are adequate arrangements in place to monitor and control the performance of any third party supplying storage and distribution services for stock owned by the Board.

Responsibility for security arrangements and the custody of keys for all stores locations should be clearly defined in writing and agreed with the designated manager, as referred to above or the Head of Procurement.

All stores systems and records should be in a form specified by the Head of Procurement or Director of Finance. Where practicable, stocks should be marked as Board property.

Records should be maintained of all goods received and a delivery note should be obtained from the supplier at the time of delivery and should be signed by the person receiving the goods. The acceptance and recording of goods received should be independent of those that requisitioned/ordered the goods. Instructions should be issued to staff covering the procedure to be adopted in respect of:

1. where the quantity delivered does not agree with that ordered;
2. where the quality/specification is unsatisfactory or not in accordance with the order;
3. where no delivery note is available; and
4. notification of suppliers of unsatisfactory deliveries.

All issue of stores must be supported by a requisition, authorised by the appropriate Budget-holding manager (or delegated officer). The Head of Procurement must be notified of all authorised signatories and their delegated authorities. The receiving department should acknowledge receipt of stores, this must be returned to the Stores Department independent of the storekeeper.

All transfers and returns should be recorded in a form approved by the Head of Procurement.

Breakages, obsolete stock and other losses of goods in stores should be recorded as they occur and a summary presented to the managers identified as responsible on a regular basis.

Stocktaking arrangements should be agreed with the Director of Finance or the Assistant Director of Finance - Financial Services, and a physical check covering all items in store performed at least once a year. The physical check should involve at least one officer other than the storekeeper. The stocktaking records should be numerically controlled and signed by the officers undertaking the check. Any surpluses or shortages revealed in stocktaking should be reported immediately to the Head of Procurement, who will investigate as appropriate. Known losses of stock items not on stores control should also be reported to the Head of Procurement. The Head of Procurement will report all losses to the Director of Finance on an annual basis, or immediately if significant or caused by fraud or theft.

Where continuous stocktaking is performed, with all stock items having been covered at least once during the year (and higher value items more frequently) and the results of these checks have proved satisfactory, it may not be necessary to carry out a full stock count. Where it is proposed not to carry out a full stock count, the permission of the Director of Finance and the agreement of the external auditors must be sought in advance.

Where a complete system of stores control is not justified, e.g. family planning stock, alternative arrangements shall require the approval of the Assistant Director of Finance - Financial Services.

The designated manager shall be responsible for ensuring there is an effective system for a review of slow moving and obsolete items and for condemnations, disposal and replacement of all unserviceable articles. These should be reported to the Director of Finance for recording in the Register of Losses (see SFI 18 – Frauds, Losses, and Legal Claims) and written down to their net realisable value.

SECTION 12

CAPITAL INVESTMENT

12.1 GENERAL

Capital Planning and Approval Processes were delegated to Health Boards by HDL (2002)40. These Instructions reflect the inherent responsibility of Boards to manage their capital needs from within available capital funds.

These Instructions should be read in conjunction with the Scottish Capital Investment Manual and the Scottish Government Construction Procurement Manual issued by the SGHSCD and NHSGGC's Construction Procurement Policy. For property transactions, the relevant guidance is contained in the NHS Property Transaction Handbook.

The Board's Chief Executive Officer is responsible for ensuring compliance with mandatory policy and guidance.

12.2 CAPITAL INVESTMENT PROCESS

An annual Capital Plan will be developed by the Capital Planning Group (CPG). This will be submitted to the Finance and Planning Committee for review prior to submission to the Board for approval.

The Capital Plan must be in line with the Board's strategic direction and reflect the objectives set out in the Corporate Plan. The Capital Plan will detail specific ring fenced allocations plus the national formula capital allocation.

The Finance and Planning Committee will approve the Boards strategy for investment in GP practices.

The Director of Finance and/or the Director of Estates and Facilities will ensure that a Business Case is produced in accordance with the SCIM guidance for all new major capital expenditure proposals.
For non IM&T projects the following should be produced:

- up to £3m a Summary Business Case
- £3m - £5m a Standard Business Case
- Over £5m an Initial Agreement, Outline Business Case and Full Business Case

For IM&T projects the following should be produced:

- up to £500,000 a Summary Business Case
- £1m - £2m a Standard Business Case
- Over £2m an Initial Agreement, Outline Business Case and Full Business Case

The Director of Finance will ensure that for every capital expenditure proposal, the CPG will be provided with assurance that the financial consequences, both capital and revenue, of the proposal have been fully identified, and are within the constraints of the Financial Plan.

The delegated limits to approve non-IM&T Business Cases are as follows:

a) The Boards delegated authority for approval of Capital expenditure proposals is £5m. Proposals above £5m will be approved by the Board prior to being submitted to the Capital Investment Group (CIG) at SGHSCD for approval. This approval will be exercised by the Finance and Planning Committee on behalf of the Board.

b) Business Cases for capital expenditure proposals between £3m and £5m will be reviewed by the CMT prior to submission to the Finance and Planning Committee for approval.
c) Authority to approve capital proposals, including unfunded proposals, up to £3m is delegated to the Corporate Management Team (CMT).
d) Authority to approve capital proposals, including unfunded proposals, up to £1m is delegated to the CPG.

A summary Business Case will be required commensurate with the value of the proposal.

The delegated limits to approve IM&T Business Cases are as follows:

a) The Board's delegated authority for approval of capital expenditure proposals is £2m. Proposals above £2m will be approved by the Board prior to being submitted to CIG for approval. This approval will normally be exercised by the Finance and Planning Committee on behalf of the Board.
b) Proposals between £1m and £2m will be approved by the CMT.
c) All proposals for IM&T expenditure over £0.5m and in accordance with the Board's approved IT Strategy will be reviewed by CPG. CPG will approve proposals up to £1m.
d) The Director of eHealth has authority to approve proposals up to £0.5m from national formula capital allocation.
e) Unfunded proposals up to £0.5m will be approved by CPG.

In the Acute Division Business Cases will be countersigned by the Chief Officer and the Assistant Director of Finance – Acute Services prior to review by the Strategic Management Group and the Acute Capital Planning Forum. Business Cases will then be submitted to the CPG for approval.

HSCP Business Cases will be countersigned by the relevant Chief Officer and the Chief Financial Officer. After approval by the HSCP Management Team it will be submitted to the CPG for approval.

On approval of a capital expenditure scheme the Head of Finance – Capital and Planning will issue a capital scheme number and update the Capital Plan.

12.3 NATIONAL FORMULA ALLOCATION

The Board receives a national formula allocation for minor works each year. The CPG allocates this funding to the Acute Capital Planning Forum, the Capital Equipment Group, and to the eHealth Senior Management Team. Each committee has responsibility to manage expenditure within their allocation. Capital expenditure proposals less than £1m will normally be funded from the minor works allocation however where a proposal has Board wide implications a Business Case should be submitted to CPG for approval with no de minimis value. Estates minor works will usually be used to reduce backlog maintenance and for statutory compliance and condition improvement projects under the direction of the Director of Estates and Facilities.

12.4 REVENUE FUNDING

Revenue funding made available by SGHSCD for a specific purpose may require minor capital expenditure to implement the service change. In these circumstances a capital scheme number will be issued by the Head of Finance – Capital and Planning and the Capital Plan updated accordingly.

12.5 CAPITAL EXPENDITURE APPROVAL PROCESS

Where a capital expenditure proposal is approved and a capital scheme number is issued by the Head of Finance – Capital and Planning, the Director of Finance or the Director of Estates and Facilities in accordance with the Board's Scheme of Delegation, will ensure that authority to proceed to procurement is issued to the manager responsible for the capital expenditure proposal.

The Property Committee will approve the following property transactions;

a) acquisitions and disposals where the value is up to £1.5m,
b) where the annual lease/rental charge is up to £1.5m.

The Finance and Planning Committee will approve all property lease/rentals and acquisitions and disposals above £1.5m.

Procurement of all capital items will be undertaken in accordance with Section 9, Non-Pay Expenditure and Section 10, Orders, Quotations and Tenders, of these SFIs.

12.6 MAJOR CAPITAL PROGRAMMES

Where CIG approval is given for major capital schemes the Board may delegate authority for managing the approved allocation to a Project Board. The management of any such projects will be structured in accordance with the Scottish Government Construction Procurement Manual issued by the SGHSCD and NHSGGC's Construction Procurement Policy. The Project Director will provide progress reports to the Board on a regular basis.

12.7 REGIONAL PLANNING

The Board is a member of the West of Scotland Regional Planning Group. The Board Chief Executive has delegated authority to approve capital expenditure included in any regional planning business case where it will become a Board asset.

12.8 PRIVATE FINANCE

Where any additional capital works are considered as a variation to any existing PPP/PFI contract the capital investment process detailed above should be applied.

12.9 THIRD PARTY DEVELOPER SCHEMES /HUB

Third party developer schemes such as hub are used to support infrastructure developments particularly within primary care settings. All projects funded by third party developers and other ways of providing new premises for independent contractors such as GPs and GDPs are subject to the same business case approvals process as any other proposed development.

The Director of Finance shall demonstrate that the capital procurement route represents value for money and genuinely transfers risk to the private sector.

The CPG will continually review the potential for approved capital schemes to be delivered through SGHSCD revenue financial models such as the hub initiative.

The hubCo arrangement is defined as an Institutionalised Public Private Partnership. In operational terms hubCo provides management services to Participants that fall into 3 distinct categories of Partnering Services:

1. **Ongoing Partnering Services** include engagement with Participants to identify and qualify new projects, formalised through the Territory Delivery Plan, or TDP, the establishment and management of the Supply Chain and supporting collaborative working between Participants through the Territory Partnering Board, or TPB. As these services are ongoing, they are paid for from an overhead charge levied on all projects delivered by hubCo, albeit capped to a level where excess income is returned to Participants who have had projects delivered by hubCo.

2. **Project Development Services** include the delivery of projects, either new build or refurbishment of community based facilities, through the selection of appropriate Supply Chain Partners and, where required, through the provision of funding for non

capital funded projects. Projects can be delivered that are design and build or just build only. The hubCo model supports both capital funded projects (D&B Contract), using the Participant's own capital or source of borrowing and revenue funded (DBFM contract), whereby hubCo sources finance for the project and the Participant pays for the cost of that finance through either internal sources (operational revenue streams) and/or external sources such as the Scottish Government. In both cases the hubCo model works on the basis that the Participant retains ownership of the asset (land and building).

Where hubCo sources finance for the project, 90% is typically provided from the external funding market (banks) by way of a funding competition, with 9.99% provided as subordinated debt and the remaining 0.01%as equity invested in a wholly owned sub hubCo. This allows for shareholders (including the public sector shareholders in hubCo) to provide investment funds. The return on this investment is capped to a level where excess income is returned to the Participant for whom the project(s) is being delivered by hubCo.

3. **Strategic Support Services** include a range of professional services at capped rates, together with Estates Planning and Service Planning services. Any Strategic Support Service with a value greater than £5,000 is also subject to competition for the selection of appropriate Supply Chain Partners.

12.10 HSCP CAPITAL PLANNING

Each HSCP will prepare a 3 year capital plan in tandem with the annual capital planning process operated by each parent organisation. This will be submitted to a HSCP Steering Group for review by senior HSCP, Board and Local Authority officers. Following this review it will be taken forward within the Board or Local Authority planning process as appropriate.

Each HSCP will update and formally approve its 3 year capital plan annually.

The nominated HSCP Chief Officer and Chief Financial Officer will be a full member of the CPG.

12.11 JOINT DEVELOPMENTS WITH LOCAL AUTHORITIES/ OTHER PARTNERS

Where a joint project is led by a Local Authority or other partner the Board must seek to ensure that NHSGGC contributions to such schemes represent value for money and are affordable. The approvals process detailed above should be applied to such schemes.

SECTION 13

ASSETS

13.1 ASSETS

Assets include all property of NHSGGC including physical assets, such as buildings, equipment, vehicles, stores, cash, and intangibles such as intellectual property or goodwill. All staff have a duty to protect and safeguard the assets of NHSGGC in the performance of their duties and it is the responsibility of the Chief Executive to ensure that there are adequate systems in place to maintain satisfactory control of fixed assets. All transactions involving property will be conducted in accordance with the procedures set out in the NHS Property Transaction Handbook and SFI 12 Capital Investment.

13.2 ASSET REGISTERS

For the purposes of these Instructions, Fixed Assets will be defined in accordance with the guidance contained in the Capital Asset Accounting Manual produced by the SGHSCD.

The Director of Finance will ensure that an Asset Register is maintained, and that all Fixed Assets are accurately and timeously recorded in the Register in accordance with the guidance contained in the Capital Asset Accounting Manual.

The Director of Finance will ensure that procedural instructions are prepared and implemented to ensure that:-

1. additions to the fixed asset register are clearly identified to an appropriate budget holder and validated by reference to:

    a. properly authorised and approved agreements, architect's certificates, supplier's invoices and other documentary evidence in respect of purchases from third parties;

    b. stores, requisitions and wages records for own materials and labour including appropriate overheads; and

    c. lease agreements in respect of capitalised assets;

2. where capital assets are sold, scrapped, lost or otherwise disposed of, their value is removed from the accounting records and each disposal validated by reference to authorisation documents and invoices (where appropriate);

3. balances on fixed assets accounts in ledgers are reconciled to balances on the fixed asset register;

4. the value of each asset is indexed to current values in accordance with methods as specified in the Capital Accounting Manual;

5. the value of each asset is depreciated using methods and rates as specified in the Capital Accounting Manual and is consistent with the agreed depreciation policy of NHSGGC; and

6. capital charges are calculated and paid as specified in the Capital Accounting Manual.

A joint operational sub-group representing each HSCP will be responsible for maintaining:

1. a joint property database incorporating all local authority and NHS Community properties., and
2. a register of jointly occupied properties recording details of joint funding agreements.

13.3 SECURITY OF ASSETS

The Director of Finance will ensure that procedures for the control of assets are prepared and implemented. These procedures will make provision for the:

1. recording of managerial responsibility for each asset;
2. identification of additions and disposals;
3. identification of all repairs and maintenance expenses;
4. physical security of assets;
5. periodic verification of the existence of, condition of, and title to, assets recorded; and
6. identification and reporting of all costs associated with the retention of an asset.

The Director of Finance will ensure all discrepancies revealed by verification of physical assets to the fixed asset register are investigated in accordance with the procedures set out in Section 18 of these Instructions.

Whilst each employee has a responsibility for the security of property of NHSGGC, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security in relation to NHS property as may be determined by the Board. Any breach of agreed security practices must be reported in accordance with instructions.

Any damage to NHSGGC's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses (Section 18 of these Instructions).

Where practical, assets should be marked as NHSGGC property.

On the closure of any premises, a physical check will be carried out and a responsible officer designated by the Chief Executive will certify a list of items held showing their eventual disposal.
(See Section 6 of these Instructions for security of cash cheques and other negotiable instruments)

13.4 DISPOSAL OF ASSETS

All disposals of assets should secure maximum income for NHSGGC (or minimise the cost where the disposal has no proceeds) other than when donated to a charitable organisation (refer to section 13.5). Assets with an estimated value greater than £1,000 should be disposed of on the open market with arrangements commensurate with the value of the disposal. Under this level, the responsible manager must record and demonstrate that the best outcome for NHSGGC has been obtained. Where the disposal incurs a cost to NHSGGC, it should be dealt with in accordance with SFI 10 Orders Quotations and Tenders.

Where a disposal is made to a related party (i.e. other than at “arms length”) the circumstances should be reported to the Head of Procurement for approval and entry in the register of Waivers to Tender.

The above does not apply to the disposal of heritable property, which must be disposed of in accordance with the relevant guidance contained in the NHS Property Transaction Handbook.

All property disposals must be in accordance with the Board’s clinical strategy and the approved Property Strategy. Where a service change requires disposal of a property the Directorate General Manager or HSCP Chief Officer as appropriate will notify the Director of Estates and Facilities.

It is the responsibility of the Property Committee to identify properties that are surplus to requirements. The Director of Estates and Facilities will ensure that disposal of the property is in line with the Board's Property and Asset Management Strategy when it has been declared surplus.

A list of properties which have been declared surplus by the Property Committee is maintained by the General Manager – Capital Planning. Where it is proposed to dispose of a surplus property and the disposal is greater than £1.5m the disposal must be approved by the Finance and Planning Committee. Disposals up to £1.5m must be approved by the Property Committee. Where the sales proceeds or Net Book Value of the disposal is greater than £500,000 additional approval must be obtained from the Chief Executive.

Any ongoing maintenance and security of the surplus property prior to disposal will be the responsibility of the Director Estates and Facilities.

13.5 DONATION OF SURPLUS ASSETS

Surplus assets will only be donated to charitable organisations which are registered with the Office of the Scottish Charity Regulator (OSCR), or an equivalent organisation, unless a request from an unregistered organisation is approved by the Chief Executive (or their nominated deputy) and the Director of Finance (or their nominated deputy).

A summary of any assets donated to charitable organisations will be provided to the Capital Planning Group.

Where the disposal proceeds of the asset are likely to be in excess of £5,000 or the net book value is £5,000 or more the Chief Executive (or their nominated deputy) and the Director of Finance (or their nominated deputy) will approve the donation of the asset.

SECTION 14

FINANCIAL INFORMATION MANAGEMENT

14.1 CODE OF PRACTICE ON OPENNESS AND FREEDOM OF INFORMATION

The Code of Practice on Openness was originally produced by the NHS in Scotland Management Executive and sets out the basic principles underlying public access to information about the NHS in Scotland. All staff have a duty to comply with the Code.

The Freedom of Information (Scotland) Act 2002 (FOISA) places an obligation on public bodies to provide information, subject to certain exemptions (such as personal information etc.), to anyone who asks for it. Any request for information in permanent form (i.e. non verbal) is a FOISA request and must be responded to, within 20 working days. A number of officers throughout NHSGGC have been trained in the requirements of FOISA. Anyone receiving a formal request for information should immediately pass it to one of the FOISA trained officers or, alternatively, the Head of Corporate Governance and Administration.

Staff should continue to respond timeously to general requests for information, where it has been customary to do so, without reference to FOISA officers.

14.2 CONFIDENTIALITY AND SECURITY

All employees have a responsibility to treat as confidential information which may be available to them, obtained by them or derived by them whilst employed by NHSGGC. They should not breach this duty of confidence by disclosing confidential information, using it in an unauthorised manner, or providing access to such information to unauthorised individuals or organisations.

Executive Directors and Heads of Department are responsible for the security and accuracy of data relating to their area of responsibility. In particular, the Director of Finance is responsible for the security of NHSGGC data processed and stored by information systems designed or procured under his responsibility. They are responsible for ensuring the accuracy and security of NHSGGC's financial data, including that held on and processed by computer.

In discharging these responsibilities, Directors should follow the guidelines contained in NHS DL (2015) 17 Information Governance and Security Improvement Measures 2015-2017.

These instructions should be read in conjunction with:-

1. the Computer Misuse Act 1990 (as amended by the Serious Crime Act 2015);

2. the Data Protection Regulations;

3. NHS CEL (2011) 25 – Safeguarding the Confidentiality of Personal Data Processed by Third Party Contractors;

4. NHS CEL (2012) 25 – NHS Scotland Mobile Data Protection Standard ; and

5. NHS Scotland Code of Practice - Protecting Patient Confidentiality.

14.3 CONFIDENTIALITY OF PERSONAL HEALTH INFORMATION

Under the terms of NHS MEL (1999) 19 and subsequent guidance issued by the SGHSCD, NHSGGC has nominated the Director of Public Health as the Caldicott Guardian to "safeguard and govern the uses made within NHSGGC of patient identifiable information including both clinical and non clinical information." The Director of Public Health will be supported by the Board's Medical Director.

14.4 RESOLUTION OF CONFLICT

The Director of Finance or the Director of Public Health must be consulted in the event of a conflict arising between NHSGGC's obligations under the Code of Practice on Openness/FOISA and the need to maintain confidentiality.

14.5 COMPUTERISED FINANCIAL SYSTEMS

The Director of Finance, who is responsible for the accuracy and security of the computerised financial data of NHSGGC, will ensure that:

1. procedures are devised and implemented to ensure adequate protection of NHSGGC's data, programs and computer hardware, for which he is responsible, from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection Regulations;

2. adequate controls exist over data entry, processing, storage, transmission and output, to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

3. adequate controls exist such that the computer operation is separated from systems development, maintenance and amendment;

4. an adequate audit trail exists through the computerised system and that such computer audit reviews as they may consider necessary are being carried out.

The Director of Finance will ensure that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

The Director of Finance will ensure that contracts for computer services for financial applications with another health organisation, other agency or external supplier shall clearly define the responsibility of all parties for the security, privacy, accuracy, completeness, and timeliness of data during processing, transmission and storage. The contract will also ensure the rights of access for audit purposes and the Director of Finance will periodically seek assurances that adequate controls are in operation.

Where computer systems have an impact on corporate financial systems, the Director of Finance must be satisfied that:

1. the acquisition, development and maintenance of such systems are in line with corporate policies including NHSGGC's ICT Strategy;

2. data produced for use with financial systems is adequate, accurate, complete and timely, and that a management audit trail exists;

3. finance staff have access to such data; and

4. such computer audit reviews as are considered necessary are being carried out.

14.6 RETENTION OF RECORDS

The Scottish Government Records Management NHS Code of Practice version 2.1 January 2012 provides guidance on the required standards of practice in the management of records for those who work within or under contract to NHSGGC. It is based on legal requirements and professional best practice. The Code of Practice encompasses the requirements of:

- Public Records (Scotland) Act 1937; as amended by the
- Public Records (Scotland) Act 2011;
- Data Protection Regulations;
- Freedom of Information (Scotland) Act 2002;
- NHS Scotland Code of Practice on Protecting Patient Confidentiality; and
- Environmental Information (Scotland) Regulations 2004;

Any other relevant laws or regulations and subsequent instructions/guidance issued by the SGHSCD must also be complied with when considering retention of records.

The Director of eHealth and the Head of Records will issue guidance on this matter as required and in cases of doubt their advice should be obtained.

14.7 INFORMATION SHARING WITH LOCAL AUTHORITIES

Section 49 of the Public Bodies (Joint Working) (Scotland) Act 2014 allows the Board to disclose information to one or more local authorities which they may reasonably require for, or in relation to the preparation of a strategic plan.

An information sharing framework will be developed in accordance with Health and Social Care Information Sharing – A Strategic Framework 2014 - 2020.

SECTION 15

ENDOWMENT FUNDS

15.1 GENERAL

Endowment funds are defined as money or property donated to the Board and held on trust for such purposes relating to services provided under the National Health Service (Scotland) Act 1978 or in relation to hospitals, or to the functions of the Board with respect to research, as the Board may think fit. The Board is appointed as a corporate trustee to hold the funds and property attributable to the endowment funds and Board members are appointed as Trustees of the endowment funds.

The endowments are constituted under the National Health Service (Scotland) Act 1978. As the NHSGGC Endowment Funds are registered with the Office of the Scottish Charities Regulator (OSCR) the Trustees must also comply with the Charities and Trustee Investment (Scotland) Act 2005.

The legally registered name of the charity is the Greater Glasgow Health Board Endowment Funds. "NHS Greater Glasgow and Clyde Endowment Funds" is the common name used to define the entity/organisation whose legal name is Greater Glasgow Health Board Endowment Funds.

The endowment Trustees are all the members of the Health Board. They are responsible for the general control and management of the charity in accordance with the NHS Greater Glasgow and Clyde Endowment Funds Charter and operating policies and procedures. Fundholders must comply with the Endowment Operating Instructions which are available on Staffnet.

15.2 RISKS ASSOCIATED WITH RECEIVING CHARITABLE DONATIONS

The purpose of the Board's endowment funds is the advancement of health through;

(a) improvement in the physical and mental health of the local population;
(b) the prevention, diagnosis and treatment of illness;
(c) the provision of services and facilities in connection to the above; and
(d) the research into any matters relating to the causation, prevention, diagnosis or treatment of illness, or into such other matters relating to the health service as the Trustees see fit.
(e) education and development in connection to the above.

Charitable donations should only be accepted by the Trustees where they are consistent with this purpose.

. The receipt of a charitable donation can attract substantial media interest, particularly where it represents a considerable amount of money. The Trustees must consider whether there are reasons why a donation might be inappropriate and should therefore be refused. While the following list is not exhaustive, it sets out circumstances where a donation should be refused.

- It specifies further requirements that the Board cannot meet.
- It specifies conditions which are incompatible with the purpose of the Board's endowments.
- Onerous conditions are attached to the donation, which are not acceptable or cannot be met. For example, where the donation is for the provision of particular equipment or facilities, and the running of which would not be cost-effective or would be unaffordable.

- The acceptance of a donation places the Board under any inappropriate obligation. For example to provide any preferential NHS treatment to parties specified by the donor.
- It would be wrong to accept the donation on ethical grounds. Acceptance of a gift from a particular source may be incompatible with the ethos of the Health Service, or be likely to alienate beneficiaries or other potential donors.
- The acceptance of the donation could result in unacceptable controversy or adverse publicity. For example, the charitable donation should not benefit the person or organisation making the charitable donation at the expense of NHS patients as a whole.
- The donation is made payable to individual members of staff.

Rather than having to refuse a potential donation, it may be possible to discuss with the donor or their legal adviser in the case of a draft will, a change to the terms of the proposal. The Board should, however, encourage people to make a general donation for Health Service purposes as this gives the greatest flexibility in the application of donations.

15.3 ACCEPTANCE OF NON-CHARITABLE DONATIONS

Donations should only be accepted where they are compatible with the "advancement of health" as this is the purpose applicable to the Board's endowment funds. Other donations should not be accepted by Endowments. Commercial Research funds or any income received in payment for services provided by the Board should be treated as exchequer rather than endowment income and administered by the Board. This guidance does not cover patients' monies or staff funds.

15.4 APPROVAL OF EXPENDITURE

Expenditure from Endowment Funds is restricted to the purpose(s) of the appropriate Fund and can only be made with the approval of the Trustees. Such approval will be delegated to the Director of Finance to authorise expenditure from General Funds against approved budgets.

Designated fundholders will be responsible for authorising/controlling expenditure incurred on those accounts for which they have designated fundholder responsibilities. They will be able to approve individual items of expenditure of up to £50,000 or such other amount as the Trustees may agree from time to time. For individual expenditure items in excess of £50,000 (or other agreed amount) up to a ceiling of £250,000, it will be necessary to obtain additional authorisation from two of the following:

- Chief Executive
- Director of Finance,
- Chief Officer, Acute Services

Individual expenditure items in excess of £250,000 must be authorised by the Trustees.

Any expenditure incurred from Endowment Funds must comply with SFI 10 – Orders, Quotations and Tenders.

15.5 CUSTODY AND SECURITY OF ASSETS

All gifts must be held in NHSGGC's name in bank accounts specified for Endowments and withdrawals may only be sanctioned by authorised signatories. The Trustees can only accept gifts for purposes relating to the advancement of health. In cases of doubt, the Director of Finance should be consulted.

All share and stock certificates and other assets relating to Endowment Funds will be held in the name of Nominees approved by the Trustees and will be deposited with the Endowment Funds' bankers or in some other secure facilities as determined acceptable to the Director of Finance. The Director of Finance will ensure a record is kept of all share and stock certificates on behalf of the Trustees. Property deeds will be held by the Central Legal Office.

Assets in the ownership of, or used by, NHSGGC as corporate trustee shall be maintained along with the general estate and inventory of assets of NHSGGC.

15.6 INVESTMENT

Endowment Funds will be invested by the investment managers appointed by the Trustees. The investment managers will have full discretionary powers but subject to any restrictions that the Trustees may impose from time to time.

The Trustees, via the Endowment Funds Management Committee, will be responsible for reviewing proposals and making recommendations to the Trustees with respect to:

1. the investment strategy including policy on investment risks;

2. the appointment of investment managers and advisers;

3. receiving reports from the investment managers; and

4. reviewing performance of the portfolio against relevant benchmarks and investment objectives.

The Director of Finance will be responsible for all aspects of the management of the investment of funds held on trust, and will advise the Trustees on the following:

1. participation in common investment funds; and

2. authorisation for the use of trust assets.

15.7 CONTROL OF ENDOWMENT FUNDS

The Director of Finance will prepare and issue procedures in respect of NHSGGC funds. These procedures should cover the following matters:

1. governing instruments for every fund;

2. controls and authorisation to open new funds;

3. treatment of offers of new funds;

4. legacies and bequests;

5. controls over and authorisation of expenditure including lists of authorised signatories;

6. the accounts and records necessary to account for all transactions;

7. fund-raising;

8. trading income;

9. investment income; and

10. periodic reporting of balances.

The Director of Finance must ensure that:

1. the Trustees are advised on banking arrangements and with Board approval, securing the appropriate banking services;

2. the Trustees receive reports on receipt of funds, investment and any other matters agreed by the Board of Trustees;

3. annual accounts are prepared in the required manner within the agreed time-scales;

4. internal and external audit services are in place;

5. the Trustees receive reports on the outcome of the annual audit;

6. the Funds' liability to taxation and excise duty is managed appropriately; and

7. legal advice is obtained where necessary.

SECTION 16

FAMILY HEALTH SERVICES

16.1 INTRODUCTION

NHSGGC has a responsibility under Part II of the NHS (Scotland) Act 1978 to provide Family Health Services (FHS). The Public Bodies (Joint Working) (Scotland) Act 2014 delegates this responsibility to Integration Joint Boards (HSCPs). The Health Board transfers the funding for FHS to the HSCPs. This funding is ring-fenced for FHS services. Each HSCP gives direction and makes payment to the Health Board which contracts the provision of FHS services to doctors, dentists, pharmacists and optometrists who are independent contractors.

16.2 INDEPENDENT CONTRACTORS

NHSGGC will maintain lists of approved contractors, and will make additions to and deletions from those lists, taking into account the health needs of the local population, and the access to existing services. All applications and resignations received will be dealt with equitably, within any time limits laid down in the contractors' NHS terms of service.

NHSGGC will ensure that:

1. lists of all contractors, for which NHSGGC is responsible, are maintained and kept up to date;

2 systems are in place to deal with applications, resignations, and inspection of premises, etc., within the appropriate contractor's terms of service;

3. there are mechanisms to monitor the quality of services provided by contractors and where this is found to be unsatisfactory that appropriate remedial action is taken; and

4. where a contractor is in breach of regulations, or whose service provision raises serious concerns, a report is submitted to the Reference Committee to consider disciplinary action;

16.3 PAYMENTS PROCEDURE

The Director of Finance will ensure:

1. that appropriate arrangements exist for payments to be made on behalf of NHSGGC by National Services Scotland;

2. payments are subject to controls which include checks that:

   (a) the Statement of Financial Entitlement issued by SGHSCD has been correctly and consistently applied;

   (b) overpayments are prevented (or if not prevented, recovery measures are initiated); and

   (c) fraud is detected;

This will involve a combination of pre and post payment verification in line with nationally agreed protocols.

3. that arrangements are in place to identify contractors receiving exceptionally high, low or no payments, and highlight these for further investigation; and

4. that a prompt response is made to any query raised by National Services Scotland – Practitioner Services Division regarding claims from contractors submitted directly to them.

5. that controls and checks are in place to cover patients claiming exemption from NHS charges.

6. that any cases of contractor or patient fraud are investigated and criminal/civil/disciplinary action is taken where appropriate.

16.4 FRAUD

Any instances of suspected fraud or other financial irregularity must be reported in accordance with SFI 18, Fraud, Losses and Legal Claims.

16.5 ENHANCED SERVICES

Directed Enhanced Services

Under the Primary Medical Services (Directed Enhanced Services) (Scotland) Directions 2018 ("DES Directions 2018"), the Board must provide primary medical services within its area or secure their provision within its area, by establishing and operating the following schemes:

- Childhood Immunisation Scheme
- Influenza and Pneumococcal Immunisation Scheme
- Violent Patients Scheme
- Minor Surgery Scheme
- Extended Hours Access Scheme
- Palliative Care Scheme
- Pertussis Immunisation Scheme
- Shingles Immunisation Scheme
- Meningitis B Immunisation Scheme

The Board must, where necessary, vary the contractor's primary medical services contract so that the plan setting out these arrangements comprises part of the contractor's contract and the requirements of the plan are conditions of the contract. Prior to issuing payments in accordance with the above paragraph, the Board will require contractors and providers who have entered into an arrangement in terms of the Extended Hours Access Scheme in the DES Directions 2018 to sign a declaration to confirm that they are meeting the requirements of the DES Directions 2018.

National Enhanced Services

The Board will determine which National Enhanced Services it wishes to implement.

The GMS Steering Group will authorise implementation of the National Enhanced Service ensuring that the financial impact is within available resources.

The national specification and guidelines for the National Enhanced Service will be applied.

Local Enhanced Services

All practices are expected to provide essential and those additional services they are contracted to provide to all their patients. This enhanced service specification outlines the more specialised services to be provided. The specification of this service is designed to cover the enhanced aspects of clinical care of the patient, all of which are beyond scope of essential services. No part of the specification by commission, omission or implication defines or redefines essential or additional services.

The GMS Steering Group will authorise implementation of the Local Enhanced Service ensuring that the financial impact is within available resources.

The specification for the Local Enhanced Service will be agreed by the GMS Steering Group in consultation with the local Medical Committee.

16.6 PAYMENT VERIFICATION

Payment Verification (PV) teams at Practitioner Services, which is part of NHS National Services Scotland, are responsible for providing assurance to the Board that the payments made on its behalf to Primary Care contractors are accurate and valid.

SECTION 17

HEALTH AND SOCIAL CARE PARTNERSHIPS

17.1 INTRODUCTION

Under the Public Bodies (Joint Working) (Scotland) Act 2014 the Board has delegated functions and resources to Health and Social Care Partnerships (HSCPs). The functions to be delegated to the HSCPs are prescribed in The Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. Each HSCP will be responsible for managing expenditure within allocated budgets.

17.2 HSCP STRATEGIC PLAN

HSCPs will produce a Strategic Plan which will incorporate a financial plan for the resources within scope of the HSCP. The Strategic Plan will set out the level of capacity required each year in all of the sectors in the care pathway and the allocation of resource within scope of the plan across the sectors. The HSCP Chief Officer will develop a case for an Integrated Budget based on a Strategic Plan which has been approved by both the Health Board and the Local Authority.

The allocations made from the HSCP to the parent bodies for operational delivery of services will be set out in the financial plan that underpins the Strategic Plan.

17.3 BUDGETS DELEGATED TO AN HSCP

The management responsibility for a budget delegated to an HSCP will be determined by the category of budget. The categories are described below.

1. **Directly Managed Budgets**
   Budgets such as District Nursing where there are no specific conditions attached due to the nature of the funding source.

2. **Directly Managed Ringfenced**
   Budgets such as GP Prescribing where the HSCP has been allocated budget management responsibility but where there are specific conditions attached. The nature of the funding source and the conditions attached dictate that the use of the funding is ring fenced for specific purposes.

3. **Managed on Behalf (MOB)**
   Service budgets where one HSCP is responsible for managing the service on behalf of one or more other HSCPs. Where such hosted arrangements apply the responsible HSCP will be expected to manage the overall service expenditure within available funds.

4. **Centrally Managed with Spend/Consumption Targets (CMT)**
   The budget will remain centrally managed but the HSCPs will actively participate in the process of service/expenditure management through the allocation of either spend targets or consumption targets.

5. **Centrally Managed**
   Budgets such as asylum seeker services and grants to voluntary organisations will continue to be managed centrally on account of their nature and/or scale.

6. Set Aside (including Acute)
The hospital services to be included in the set aside budget are listed in Schedule 3 Part 2 of the Public Bodies (Joint Working) (Prescribed Health Board Functions) (Scotland) Regulations 2014. Only clinical service budgets will be included; services which are not provided by health professionals, such as catering and cleaning services, will not be included in the set aside budget delegated to HSCPs.

7. Other (including Notional Budgets)
FHS Non Cash Limited and other budgets where HSCPs are unable to influence expenditure levels but where they have a monitoring role. Such budgets are regarded as notional allocations.

Where a Local Authority employee is to be either a budget holder or is to be delegated authority to approve expenditure of any type it is the responsibility of the relevant Chief Officer to ensure that the individual has the necessary access to the Board's policies and procedures and the relevant IT systems (e.g. procurement) and the capability to competently implement the Board's policies and procedures.

Local Authority Employees will remain employees of the relevant Local Authority and will not become employees of the Board unless expressly agreed otherwise. Nonetheless, it is anticipated that for the limited purpose of delivering the relevant Directed Functions, such Local Authority Employees will require to comply with certain relevant Board policies, including these SFIs.

Directed Functions means a function of which an Integrated Joint Board has directed the Board to carry out under s.26 (1) of the Public Bodies (Joint Working) (Scotland) Act 2014. Local Authority Employee means an employee of a Local Authority which is party to an Integration Scheme with NHSGGC, in circumstances where that employee carries out Delegated Functions.

17.4 VIREMENT

An HSCP may vire resources across partners to enable implementation of strategic plans. Virement proposals will require the support and commitment of the HSCP Chief Financial Officer, the Board Director of Finance and the Local Authority Finance Officer. Agreed virements will be paid to partner authorities through the resource transfer mechanism.

Where virement of funds may have an impact on service provision by another HSCP, area wide partnership or Board wide managed service, the proposal must be supported by the head of that service and by the relevant Chief Financial Officers.

17.5 NON RECURRING FUNDING

HSCPs may receive non-recurring funding in any one year from the Board which relates to a specific activity. HSCPs must account for such funding as required and must not utilise it for purposes other than funded activity. HSCPs should not plan for a recurrence of such funding.

17.6 RESERVES

HSCPs may hold reserves subject to the agreed reserves policy.

17.7 CAPITAL PLANNING

Each HSCP will undertake a strategic review of service priorities in order to develop a 3 year Capital Plan. This will be reviewed annually in tandem with a review of its premises needs, including existing owned and leased clinical and office premises.

17.8 BUSINESS CASES

Where NHSGGC funding is the sole targeted source of finance the Business Case guidance in Section 2 of these SFIs should be followed.

SECTION 18

FRAUD, LOSSES AND LEGAL CLAIMS

18.1 FRAUD, OTHER CRIMINAL OFFENCES AND FINANCIAL IRREGULARITIES

The Chief Executive, as Accountable Officer, is responsible for ensuring that all suspected fraud, theft, bribery, corruption and other financial irregularities are investigated and appropriate action taken. Operational responsibility for this is delegated to the Director of Finance and/or NHSGGC's Fraud Liaison Officer, who will take/instruct the necessary action and keep the Chief Executive informed of any salient issues, or where controversy may arise. NHSGGC has a formal Fraud Policy, which sets out the Board's policy and individuals' responsibilities. The Policy is supported by a formal Partnership Agreement with NHS Counter Fraud Service which details the action to be taken when fraud, theft, corruption or other financial irregularities are suspected (ensuring compliance with circular DL (2019)04. The following paragraphs provide an outline of the requirements but the Fraud Policy should be referred to for further detail.

The definitions of fraud, corruption and embezzlement (generally referred to as "fraud") and the related activity of theft are contained in the Fraud Policy, and are as follows:-

Fraud: the use of deception with the intention of obtaining an advantage, avoiding an obligation or causing loss to another party.

Bribery or Corruption: the offering, giving, soliciting or acceptance of an inducement or reward which may influence the action of any person.

Embezzlement: the felonious appropriation of property by a person to which it has been entrusted.

Theft: the dishonest appropriation of property without the consent of the rightful owner or other lawful authority.

NHSGGC will take appropriate legal and/or disciplinary action against any employee, director, contractor or other third party if any of the above offences are found to be proven. In instances where there is sufficient evidence to support a criminal prosecution there is a presumption that a referral will made to the Procurator Fiscal for consideration.

Every officer has a duty to report, without delay, any instances of fraud, corruption, embezzlement, theft or other financial irregularities that they discover. This also includes any reasonably held suspicions that such circumstances have occurred (or are about to occur). This should normally be reported to the officer's line manager, in the first instance, but may be directly to the Fraud Liaison Officer if there are concerns about reporting to the line manager. NHSGGC encourages anyone having reasonably held suspicions of fraud, or other irregularity, to report it. Individuals should have no fear of reporting such matters unless they know their allegations to be groundless and/or raised maliciously.

In cases where fraud, bribery, corruption or embezzlement is suspected, all investigations must be carried out by staff from NHS Counter Fraud Service. Line managers must therefore immediately contact the Fraud Liaison Officer who will arrange preliminary discussions with NHS Counter Fraud Service. No action should be taken, that may prejudice the outcome of any potential criminal prosecution, prior to consultation with the Fraud Liaison Officer and NHS Counter Fraud Service. This does not however prevent immediate action being taken where there are issues regarding safety and/or suspicions that evidence may be destroyed. Further guidance is available from the Fraud Liaison Officer.

In cases of theft, line managers should contact the police. Local managers should assume that they have delegated authority to investigate minor thefts (subject to the approval of their service head) but should still contact the Fraud Liaison Officer in cases of doubt and where they may require specialist assistance. Any major thefts, a series of thefts or theft involving some form of deception should be discussed immediately with the Fraud Liaison Officer as these may require investigation by NHS Counter Fraud Service. There is a presumption that all thefts should be reported to the police and that the crime reference should be entered on the Datix Report/ Form IR1 and Loss Report. Managers must submit a copy of their formal investigation report (which will be satisfied by a Datix Report/Form IR1 or Loss Report in simple cases) to NHSGGC's Fraud Liaison Officer.

NHSGGC is not authorised to carry out any form of covert surveillance. If any manager considers that such a measure is necessary to detect or prevent a crime then they should contact the Fraud Liaison Officer to arrange assistance from the NHS Counter Fraud Service.

It is possible that any instance of fraud or other financial irregularity, may attract enquiries from the media or other outside sources. Staff should not make statements to the media regarding any financial irregularity, as this could prejudice the outcome of any criminal enquiry or proceedings. Any enquiries from the media or third parties should, in line with normal NHSGGC policy, be referred to NHSGGC's Communications Office, which will provide an appropriate response after consultation with the NHS Counter Fraud Service and/or the Fraud Liaison Officer.

18.2 LOSSES AND SPECIAL PAYMENTS

The Director of Finance will ensure that procedural instructions on the recording of, and accounting for, condemnations, losses and special payments are prepared and issued.

Any officer discovering or suspecting a loss of any kind will immediately inform their local manager. The manager will complete a loss form which will be signed by a budget holder and submitted to Financial Services. Losses in excess of the Budget Holder's delegated authority to write off losses should also be authorised by the appropriate Chief Officer. Where the loss is due to fraud or theft, the manager will immediately act as detailed at section 18.1 above.

The Director of Finance will ensure that a losses register in which details of all losses and compensations will be recorded as they are known is maintained.

The Board will approve the writing off of losses, within the limits delegated to it from time to time by the SGHSCD, except that delegated responsibility may be given by the Board to the Chief Executive or other officers. Any significant losses written off under this delegated authority will be reported to the Audit Committee of NHSGGC. Details of the delegated levels of authority are given in the Scheme of Delegation.

No losses or special payments that exceed the limits delegated to NHSGGC by the SGHSCD will be made without their prior approval.

The Director of Finance is authorised to take any necessary steps to safeguard NHSGGC's interest in bankruptcies and company liquidations.

For any loss, the Director of Finance will consider whether

1. any insurance claim can be made against insurers; or
2. legal action can be taken to recover all or part of the amount of the loss.

All changes to securities will require the approval of the Director of Finance since they affect the Board's financial exposure and risk of bad debts

18.3 CLAIMS FOR MEDICAL/CLINICAL NEGLIGENCE

The Head of Board Administration will arrange for the Acute Services Division and HSCPs to hold a register of claims for medical and clinical negligence including details of payments made.

18.4 OTHER LEGAL CLAIMS

The Head of Corporate Governance and Administration will arrange for the Acute Services Division and HSCPs to hold a register of other legal claims e.g. under Health and Safety legislation.

18.5 DISPOSALS AND CONDEMNATIONS

The procedures for the disposal of assets are set out in these instructions at Section 13 - Assets.

The Director of Finance will ensure that procedures for the recording and condemnation of all unserviceable items are prepared and issued.

18.6 REPORTING

Results of this work will be reported to the Audit Committee.

SECTION 19

PATIENTS' PRIVATE FUNDS AND PROPERTY

19.1 PROCEDURE

NHSGGC has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, found in the possession of unconscious or confused patients, found in the possession of mentally disordered patients, or found in the possession of patients dying in hospital. Such property shall be dealt with as provided below and in accordance with the Adults with Incapacity (Scotland) Act 2000.

Patients or their guardians, as appropriate, shall be informed before or at admission by:

- notice and information booklets;
- hospital admission documentation and property records;
- the oral advice of administrative and/or nursing staff responsible for admissions;

that NHSGGC will not accept responsibility or liability for patients' property brought into Board premises, unless it is handed in for safe custody and a receipt is obtained acknowledging property handed over.

The Director of Finance will ensure that there are detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of property of deceased patients and patients transferred to other premises) for all staff whose duty it is to administer, in any way, the property of patients. These instructions will incorporate the guidance on this subject issued from time to time by the SGHSCD and will be in a form approved by the Supervisory Body.

Any money or property handed over for safekeeping will be evidenced by the issue of an official receipt.

Records of patients' property shall be completed by a member of the hospital staff in the presence of a second member of staff and in the presence of the patient or the personal representative, where practicable. It should be signed by the member of staff and by the patient, except where the latter is restricted by physical or mental incapacity, in which case it should be witnessed by the signature of a second staff member.

Patients' income, including pensions and allowances, shall be dealt with in accordance with current SGHSCD guidelines and Department of Work and Pensions regulations.

Where monies or valuables are handed in other than to the Patients' Funds Cashier then they will be held securely and transferred to the Patients' Funds Cashier at the first reasonable opportunity.

Patients' funds will be banked and administered in accordance with instructions provided by the Director of Finance. Any funds not required for immediate use will be lodged in an interest bearing account with interest being credited to individual patients based on the level of funds held by each patient. Bank and funds reconciliations should be prepared on a monthly basis and reviewed by a more senior officer not involved in the day to day operation of the funds.

In the case of patients incapable of handling their own affairs, and unless their affairs are managed under legal authority by some other party, their affairs will be managed in accordance with the Adults with Incapacity (Scotland) Act 2000 and the associated policies approved by the Board's Supervisory Body.

In all cases where property, including cash and valuables, of a deceased patient is of a total value of more than £10,000 (or such other amount as may be prescribed by legislation and advised by the SGHSCD), production of a Confirmation of Estate will be required before any of the property is released. Where the total value of the property is less than £10,000 forms of indemnity will be obtained (although confirmation of estate should still be obtained in instances where dispute is likely).

In respect of a deceased patient's property, if there is no will and no lawful kin, the property vests in the Crown, and particulars will, therefore, be notified to the Queen's and Lord Treasurer's Remembrancer.

Staff should be informed on appointment, by the appropriate departmental or senior manager, of their responsibilities and duties for the administration of the property of patients.

Staff should not benefit directly or indirectly from the management of patients' private funds or property. Where it could be perceived that a member of staff may benefit, directly or indirectly (e.g. through accompanying a patient on holiday), then the expenditure and activity should be approved by the Multi-disciplinary Review Team.

The Board is not authorised to hold funds or valuables on behalf of patients in a community setting. Staff should decline requests to do so otherwise they could become personally liable in the event of loss.

19.2 OUTSIDE CONTRACTORS

Where NHSGGC contracts with a private, voluntary sector or non NHS body for the provision of NHS patient care, the Director of Finance will ensure that the relevant contract specifies standards to be adopted for the administration and management of patients' private funds and property.

Detailed instructions, equivalent to those adopted by the Health Board, will be required and will form the basis of the standards required contractually of health care providers in respect of the administration and control of patients' funds and property. The Director of Finance will ensure the performance of partnership providers is monitored and measured against these procedures.

SECTION 20

USE OF CONSULTANCY SERVICES (NON-MEDICAL)

20.1 DEFINITION

An external consultancy service is defined as:
a) an ongoing exchange of intellectual or professional information; where
b) the commission ends on completion of a defined output; and
c) the day to day management of the consultant remains with the supplier.

External consultants should only be used where the required skills and expertise to deliver the project cannot be provided internally.

20.2 MANAGEMENT CONSULTANTS

Where use of management consultants is being considered, the guidance contained in Circular NHS MEL (1994) 4 must be observed. This guidance covers the engagement, control and reimbursement of fees to management consultants.

20.3 CAPITAL PROJECTS

Where external consultants such as architects, design consultants, surveyors etc are engaged on capital projects, including IM&T projects, the Board should follow the guidance contained in SCIM including the requirement for a post project evaluation.

20.4 REVENUE FUNDED PROJECTS

External consultants for revenue funded projects should only be engaged where it is considered to be the best way to deliver an outcome of value to the Board.

All engagements must have a clearly defined remit and outcome which will enable the Board to deliver its approved clinical strategy.

Any internal resources required to support the external consultant should be identified prior to engaging the external consultant.

A post project evaluation should be undertaken to assess whether the required outcome has been achieved.

20.5 PROCUREMENT

Engagement of all external consultants will be undertaken in accordance with Section 9, Non-Pay Expenditure and Section 10, Orders, Quotations and Tenders, of these SFIs.

All legal services will be obtained through NHS Central Legal Services (CLO) other than where the Board has appointed external legal advisers to a specific project. Note that prior approval will be required before consulting CLO.

NHS Greater Glasgow and Clyde Scheme of Delegation

NHS Greater Glasgow and Clyde Scheme of Delegation

Lead Manager	Head of Financial Governance
Responsible Director	Director of Finance
Approved By	NHSGGC Board
Date Approved	tba
Date for Review	April 2020
Replaces Previous Version	Scheme of Delegation – 4th Revision, approved April 2018

NHS Greater Glasgow and Clyde
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1. MATTERS RESERVED FOR THE BOARD

Background

As defined in the NHS Circular HDL(2003) 11 “Moving Towards Single System Working”, Greater Glasgow and Clyde NHS Board is a board of governance, delivering a corporate approach to collective decision making based on the principles of partnership working and devolution of powers. Local leadership will be supported by delegating financial and management responsibility as far as is possible consistent with the Board’s own responsibility for governance.

The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Board to delegate some of its functions to an Integration Joint Board in order to create a single system for local joint strategic commissioning of health and social care services. The Integration Joint Board may, by direction, require the Board to carry out a function delegated to the integrated authority. These functions, which the Board is directed to carry out by the Integration Joint Board, are subject to the Board’s Scheme of Delegation.

The Board has a corporate responsibility for ensuring that arrangements are in place for the conduct of its affairs and that of its operating sectors and partnerships, including compliance with applicable guidance and legislation, and ensuring that public money is safeguarded, properly accounted for, and used economically, efficiently and effectively. The Board has an ongoing responsibility to ensure that it monitors the adequacy and effectiveness of these arrangements in practice.

The Board is required to ensure that it conducts a review of its systems of internal control, including in particular its arrangements for risk management, at least annually, and to report publicly on its compliance with the principles of corporate governance codes.

The following matters shall be reserved for agreement by the Board: -

1. Improving the Health of the population (shared responsibility with the Integration Joint Partnership Boards (HSCPs);
2. Setting strategic direction and development;
3. Development and Implementation of the Annual Operational Plan;
4. Monitoring of aggregated/exception reports from the Acute Services Committee, the Finance Planning and Performance Committee and HSCP IJBs on key performance indicators;
5. Resource Allocation (for both Capital and Revenue resource allocation);
6. Approval of Annual Accounts;
7. Scrutiny of Public Private Partnerships;
8. Approve appointment process of Executive Directors;
9. NHS Statutory Approvals;
10. Corporate Objectives;
11. Sets Values of the organization;
12. Corporate governance framework including
    - Standing Orders
    - Establishment, remit, and reporting arrangements of all Board Standing Committees
    - Scheme of Delegation
    - Standing Financial Instructions

2. MATTERS DELEGATED TO OFFICERS OF THE BOARD

The Corporate Management Team (CMT) is the senior management decision-making body for NHSGGC and carries out an overview of the Board's responsibilities in developing strategy, policy and assessing performance against agreed objectives.

It also manages the business of the NHS Board by reviewing and endorsing Board-wide strategies, policies and actions to ensure a corporate position is achieved prior to submission to the NHS Board and its Standing Committees for consideration and approval.

Any reference in this scheme to a statutory or other provision shall be interpreted as a reference to that provision as amended from time to time by any subsequent legislation.

Any power delegated to an officer in terms of this scheme may be exercised by such an officer or officers of his or her department as the officer may authorise in writing.

3. SCHEME OF DELEGATION ARISING FROM BOARD STANDING ORDERS

Line	Area of Responsibility	Committee Approval Required	Officer Responsible
1	Maintenance of Register of Board Members interests		Head of Corporate Governance and Administration
2	Maintenance of a Register of gifts/hospitality for Board members		Head of Corporate Governance and Administration
3	Document or Proceeding requiring authentication by the Board		One Board Member, the Head of Corporate Governance and Administration and the Director of Finance
4	Execution of Documents on behalf of Scottish Ministers relating to Property transactions		Chief Executive/ Director of Finance/ Medical Director / Chief Officer – Acute Services/Director of Estates and Facilities.

4. SCHEME OF DELEGATION ARISING FROM BOARD STANDING FINANCIAL INSTRUCTIONS

A scheme of delegation operates for various Standing Financial Instructions (SFIs), each of which is described in the tables that follow the list below. The list below therefore includes a cross reference to the relevant section of the standing financial instructions.

Table	Title	SFI section
4.1	Allocations, Business Planning, Budgets, Budgetary Control and Monitoring	2
4.2	Annual Accounts and Reports	3
4.3	Audit	4
4.4	Banking Arrangements	5
4.5	Healthcare Service Provision	7
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4.15	Patients' Private Funds and Property	19

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Table 4.1 Allocations and Budgets

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Preparation and approval of Revenue and Capital Financial Plans	Finance, Planning and Performance Committee and onwards to Board	Director of Finance	Revenue Resource Limit/Capital Resource Limit
2	Preparation and submission of Budgets		Director of Finance	Revenue Resource Limit
3	Preparation and submission of Budgets - Acute Division		Director of Finance	Limit as per Financial Plan
4	Agreeing strategic direction for HSCP Strategic Plans	Finance, Planning and Performance Committee and onward to the Board	Chief Executive	Resources within scope of Integration Plan
5	Establishment and maintenance of Budgetary Control System		Director of Finance	
6	Delegation of Budgets		Chief Executive/Director of Finance	Limit as per Financial Plan
7	Approval of Change Programmes	Finance, Planning and Performance Committee (where proposal includes major service change/ workforce change or where revenue implications are unfunded or >£1.5m)	Chief Executive/Director of Finance	Within available resources
8	Authority to use N/R budget to fund recurring expenditure		Chief Executive	Within available resources
9	Virement of budget – Acute Services		Chief Operating Officer /Director of Finance	Within available budget in support of agreed Board strategy
10	Virement of budget – HSCP	Integrated Joint Board	HSCP Chief Officers (requires support of Board Director of Finance and Local Authority Finance Officer)	Within available budget in support of agreed Strategic Plan

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Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
11	Authority to commit expenditure for which no provision has been made in approved plans/budgets	Board	Chief Executive/ Director of Finance	Board – within available resources Chief Executive up to £2m Director of Finance up to £250k

Table 4.2 Annual Accounts and Reports				
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**	**Limits Applying**
1	Submission of monitoring returns		Director of Finance	In accordance with SGHSCD requirements
2	Approval of Annual Accounts	Board	Chief Executive	In accordance with Accounts Manual
3	Preparation of Governance Statement	Audit and Risk Committee and onwards to Board	Director of Finance	In accordance with Accounts Manual

Table 4.3 Audit				
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**	**Limits Applying**
1	Conduct of Business and Stewardship of Funds under Board control	Audit and Risk Committee	Chief Executive	In accordance with SGHSCD requirements
2	Provision of Internal Audit Service	Audit and Risk Committee	Director of Finance	In accordance with the Public Sector Internal Audit Standards
3	Appointment of external auditors	Scottish Ministers	Director of Finance	In accordance with the Audit Scotland Code of Audit Practice

Table 4.4 Banking Arrangements

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Opening of Bank accounts in the Board's name	Board	Director of Finance	N/A
2	Notification to bankers of authorised signatories on bank accounts	Board	Director of Finance	N/A
3	Transfers to/ from GBS Account; to/ from Bank Accounts		2 signatories from panel authorised by the Board	N/A
4	BACS/CHAPS/SWIFT /Faster Payments/ cheque/ Payable Order payments		2 signatories from panel authorised by the Board	N/A
5	Direct Debit/Standing Order mandates		1 signatory from panel authorised by the Board	N/A

**BACS – Bankers Automated Clearing System; CHAPS – Clearing Houses Automated Payment System;*

SWIFT – Society for World-wide Interbank Financial Telecommunication;

GBS – Government Banking Service

Table 4.5 Contracts/Service Level Agreements

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Contracts/ Service Level Agreements	CMT and onwards to Finance, Planning and Performance Committee	Constituent members of the CMT	Finance, Planning and Performance Committee approval required for all agreements >£1.5m
2	Resource Transfer	Finance, Planning and Performance Committee	HSCP Chief Officers	Within approved budget
3	Setting of Fees and Charges: income generation - Board		Director of Finance/ Assistant Director of Finance – Corporate Services and HSCPs/ Assistant Director of Finance - Financial Services	Where not determined by SGHSCD or statute
4	Setting of Fees and Charges: Private Patients, overseas visitors, income generation and other patient related services – Acute Services		Director of Finance/ Assistant Director of Finance – Acute Services/ Directorate Heads of Finance	Where not determined by SGHSCD or statute
5	Setting of Fees and Charges: Private Patients, overseas visitors, income generation and other patient related services - Health and Social Care Partnerships		Director of Finance/ Assistant Director of Finance – Corporate Services and HSCPs/ HSCP Chief Financial Officers	Where not determined by SGHSCD or statute

Table 4.6 Pay expenditure

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Human Resource policies	Staff Governance Committee	Director of Human Resources and Organisational Development	
2	Responsibility for implementing changes to terms and conditions of service	CMT	Director of Human Resources and Organisational Development	Within national guidance
3	Preparation of contracts of employment		Director of Human Resources and Organisational Development	Compliance with current legislation and agreed terms and conditions
4	Approval of Severance agreements – Executive cohort	Remuneration Sub-Committee	Chief Executive (Chairman where severance agreement is for Chief Exec.) and Director of Human Resources and Organisational Development	
5	Approval of Severance agreements -all other staff		Director of Human Resources and Organisational Development / Director of Finance	Compliance with current legislation and agreed terms and conditions; within available funding
6	Settlement of employment litigation claims		Director of Human Resources and Organisational Development with a Board Director	
7	Executive and Senior Management Pay	Remuneration Sub-Committee	Director of Human Resources and Organisational Development	Compliance with current legislation and agreed terms and conditions
8	Engagement, termination, re-engagement, re-grading of staff		Budget Holder	Within approved budget and funded establishment and in accordance with approved HR policies
9	Approval of hours worked		Budget Holder	Within approved budget
10	Approval of Leave		Budget Holder	In accordance with agreed Ts&Cs
11	External contractors		Budget Holder	Within approved budget

Table 4.7 Non-Pay Expenditure

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Procurement Strategy	Finance, Planning and Performance Committee	Director of Estates and Facilities	N/A
2	Oversight of Procurement Strategy	Procurement Steering Group	Director of Estates and Facilities	N/A

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Table 4.8 Orders, Quotations and Tenders

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Request for tender/purchase (including specification) revenue - Health supplies/ services revenue - other supplies/ services expenses		Budget holder	In accordance with approved strategy/ Business Case/ Project Authorisation Checklist
2	Approval of Non Pay revenue expenditure	Finance, Planning and Performance Committee over £5m;	Chief Executive up to £5m; Director of Finance up to £4m; Chief Officer – Acute Services up to £4m; Acute/Corporate Directors up to £1m; HSCP Chief Officers up to £1m.	Within limits of available budget
3	Approval of Non IM&T Capital expenditure	Finance, Planning and Performance Committee over £3m; CMT up to £3m; Capital Planning Group (CPG) up to £1m	Chief Executive up to £5m; Director of Finance up to £4m;Director of Estates and Facilities up to £4m; Senior General Managers - Capital Planning up to £1m;	Within limits of approved scheme
4	Approval of IM&T Capital expenditure	Finance Planning & Performance Committee over £2m; CMT up to £2m; CPG up to £1m	Chief Executive up to £2m; Director of Finance up to £2m;	Within limits of approved scheme
5	Placing external commitments/ contract awards	Finance, Planning & Performance Committee over £5m;	Chief Executive up to £5m; Director of Finance up to £4m; Head of Procurement up to £2m;	Approval requests will be accompanied by a tender report signed by the Head of Procurement supporting award of the contract.
6	Maintenance of Contract Register		Head of Procurement	
7	Maintenance of Tender Register		Head of Procurement; Head of Department for each Board Procurement Lead	
8	Waivers to Tender		Relevant Director and Head of Procurement; Director of Finance when >£250k or>£50k	Required >£10k. Additional requirements for DoF sign off when >£250k (urgent or no competition) or >£50k when tender process not followed

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Note: Where a proposal by an HSCP requires capital expenditure the proposal will be approved by the HSCP Board prior to submission to the Capital Planning Group for consideration.

Table 4.9 Management and Control of Stock

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Issue of Stores recording and operating procedures		Director of Estates and Facilities	All stocks
2	Day to day management and security arrangements		Director of Pharmacy	Pharmacy stock
3	Day to day management and security arrangements		Director of eHealth	IM&T stock
4	Day to day management and security arrangements		Director of Estates and Facilities	All other stocks

Table 4.10 Capital Investment

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Approval of Business Cases - non IM&T	CIG Finance, Planning and Performance Committee CMT CPG	Director of Estates and Facilities	SGHSCD CIG approval required over £5m Finance, Planning & Performance Committee over £3m CMT up to £3m CPG up to £1m (where expenditure not included in approved Capital Plan)
2	Approval of Business Cases -IM&T	CIG Finance, Planning and Performance Committee CMT	Director of eHealth	SGHSCD CIG approval required over £2m Finance, Planning and Performance Committee approves prior to submission to CIG CMT up to £2m;
3	Property acquisitions/ disposals	Finance, Planning and Performance Committee	Director of Estates and Facilities	All property acquisitions and disposals Where sale proceeds or NBV of a disposal is >£500k additional Chief Executive approval required
4	Lease/rental agreements	Finance, Planning and Performance Committee	Chief Executive/ Director of Finance /Director of Estates and Facilities / Medical Director/ Chief Operating Officer	All lease/rental agreements
5	Strategy for Investment in GP practices	Finance, Planning and Performance Committee	Director of Estates and Facilities	
6	Concessionary Leases (a lease at below market terms to voluntary/community/ social enterprise)	Finance, Planning & Performance Committee	Director of Estates and Facilities	All concessionary leases

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Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
7	Hub contracts (revenue funded)	Board (exercised by Finance, Planning and Performance Committee on behalf of Board)	Director of Estates and Facilities	Within limits of agreed project budget

Table 4.11 Management of Endowment Funds

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Expenditure budget for general funds	Endowment Trustees		
2	Approval of expenditure from Endowment Funds	Endowment Trustees	Endowment Trustees Fundholder/ authorised signatory plus Chief Exec. or Director of Finance or Chief Operating Officer Fundholder/ authorised signatory to fund	Over £250,000 Between £250,000 and £50,000 Up to £50,000
3	Appointment to endowment funded posts	Endowment Management Committee	Director of Finance	All Endowment funded posts
4	Maintenance of Accounts and Records		Director of Finance	
5	Access to share and stock certificates, property deeds		Director of Finance	
6	Opening of Bank accounts in the Endowment Fund name		Director of Finance	
7	Acceptance of endowment funds	Endowment Trustees	Director of Finance	Funds may only be accepted where consistent with the charitable purpose of the Endowment Funds
8	Correspondence re legacies and giving good discharge to executors		Director of Finance	
9	Investment of Endowment Funds	Endowment Trustees	Director of Finance	
10	Nominee for grants of probate or letters of administration		Director of Finance	

Table 4.12 Family Health Services

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Agreement of General Medical Services (GMS) budget	Board	Chief Executive/ Director of Finance	Within limits of Financial Plan
2	Preparation of local aspects of GMS Contracts		Chief Officer Renfrewshire HSCP	
3	Agreement of local aspects of GMS Contracts	GMS Steering Group	Chief Officer Renfrewshire HSCP	Chief Executive/ Director of Finance counter signature required
4	Individual GP Practice Contract changes		Lead Chief Officer Primary Care Support and HSCP Chief Officers	
5	GMS payments		Practitioner Services on behalf of the Chief Executive	In accordance with NHS (General Medical Services Contracts) (Scotland) Regulations 2004 and subsequent amendments
6	Monitoring of contractors covered by GMS Contract		Head of Primary Care Support on behalf of the Chief Executive	
7	General Pharmaceutical Service payments		Practitioner Services on behalf of the Chief Executive	In accordance with NHS (Pharmaceutical Services) (Scotland) Regulations 2009 and subsequent amendments
8	Monitoring of contractors covered by GPS Contract		Head of Pharmacy and Prescribing Support on behalf of the Chief Executive	
9	General Dental Service payments		Practitioner Services on behalf of the Chief Executive	In accordance with NHS (General Dental Services) (Scotland) Regulations 2010 and subsequent amendments
10	Monitoring of contractors covered by GDS Contract		Chief Officer East Dunbartonshire HSCP	
11	General Ophthalmic Service payments		Practitioner Services on behalf of the Chief Executive	In accordance with NHS (General Ophthalmic Services) (Scotland) Regulations 2006 and subsequent amendments
12	Monitoring of contractors covered by GOS Contract		Head of Primary Care Support on behalf of the Chief Executive	
13	Verification of FHS payments		Practitioner Services on behalf of the Chief Executive	In accordance with DL(2018) 19 and Partnership Agreement with Practitioner Services

Table 4.13 Health and Social Care Partnerships

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Delegation of functions to IJBs	Board	Chief Executive	In accordance the Public Bodies (Joint Working) (prescribed Health Board Functions) (Scotland) Regulations 2014 and approved Integration Schemes
2	Delegation of funds to IJBs	Finance, Planning and Performance Committee	Chief Executive/ Director of Finance	In accordance with Strategic Plan and within limits of Financial Plan
3	Agreement of Strategic Plans for IJBs	Finance, Planning and Performance Committee onwards to Board	Chief Executive	In accordance with Integration Scheme and within limits of Financial Plan
4	Oversight of performance outcomes for delegated services	Finance, Planning and Performance Committee	HSCP Chief Officers	In accordance with Integration Scheme

Table 4.14 Fraud, losses and Legal Claims

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
1	Notification of discovered fraud/criminal offences to SGHSCD		Director of Finance	
2	Writing off of losses	SGHSCD		Over £20,000 other than losses relating to: - Stores/Procurement - Fixed Assets(other than equipment related fraud/ theft where the limit is over £20,000) - Abandoned RTA claims In these exceptions the limit is over £40,000
3	Writing off of losses		Chief Executive/ Director of Finance/ Director of Human Resources and Organisational Development/ Director of Corporate Communications/ Director of Public Health/ Director of eHealth / Chief Operating Officer/ HSCP Chief Officers/ Head of Corporate Governance and Administration	Up to limit of Board delegated authority (see above)
4	Ex-gratia payments	SGHSCD		Financial loss over £25,000; Extra contractual payments over £20,000; Other payments over £2,500
5	Ex-gratia payments		Chief Executive/ Director of Finance/ Director of Human Resources and Organisational Development/ Director of Corporate Communications/ Director of Public Health/ Director of eHealth / Chief Officer Operating/ HSCP Chief Officers/ Head of Corporate Governance and Administration	Up to limit of Board delegated authority (see above)
6	Maintenance of medical negligence claims register		Head of Corporate Governance and Administration	

NHS Greater Glasgow and Clyde
Scheme of Delegation

Line	Area of Responsibility	Committee Approval Required	Officer Responsible	Limits Applying
7	Maintenance of legal claims register		Head of Corporate Governance and Administration	
8	Overview of claims, liability and settlement status	Audit and Risk Committee	Head of Corporate Governance and Administration	
9	Settlement of legal claims and Compensation Payments	Audit and Risk Committee onwards to SGHSCD		Clinical claims Over £250,000; Non–Clinical claims over £100,000
10	Settlement of legal claims and Compensation payments		Nominated Directors and Head of Corporate Governance and Administration	Clinical claims up to £250,000; non–Clinical claims up to £100,000
11	Action to safeguard the Board's interests in bankruptcies and company liquidations.		Director of Finance	

Table 4.15 Patients Private Funds and Property				
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**	**Limits Applying**
1	Authorisation of Manager and Establishments to manage residents affairs		Chief Officer – Operations, Glasgow City HSCP as Lead Director for the Supervisory Body	Within the terms of the Adults with Incapacity (Scotland) Act 2000.
2	Monitoring and reviewing arrangements for the management of residents affairs		Chief Officer – Operations, Glasgow City HSCP as Lead Director for the Supervisory Body	Within the terms of the Adults with Incapacity (Scotland) Act 2000.
3	Establishment of arrangements for the safe custody of patients' and residents' property		Chief Executive	Within the terms of the Mental Health Act 1984, Adults with Incapacity Act 2000 and guidance laid down by the Scottish Government.
.4	Arrangements for the opening and management of bank accounts		Director of Finance	
5	Establishment of detailed procedures for the safe custody and management of patients' and residents' property		Director of Finance	
6	Provision of a receipts and payments statement in the approved format annually		Director of Finance	
7	Preparation and Approval of Annual Accounts	Board	Director of Finance	

5. SCHEME OF DELEGATION ARISING FROM OTHER AREAS OF CORPORATE GOVERNANCE

A Scheme of Delegation operates for the areas of non financial corporate governance listed below.

Table	Title
5.1	Clinical Governance
5.2	Staff Governance
5.3	Risk Management
5.4	Health Planning
5.5	Performance Management
5.6	Information Governance
5.7	Communication
5.8	Emergency and Continuity Planning
5.9	Public Health
5.10	Other Areas

Table 5.1 Clinical Governance			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Clinical Governance Strategy/Framework	Clinical and Care Governance Committee onward to Board	Medical Director
2	Quality Strategy	Clinical and Care Governance Committee onward to Board	Nurse Director
3	Approval of research and development studies including associated clinical trials and indemnity agreements for commercial studies	Research and Ethics Committees with Annual Report to Clinical Care Governance Committee	Medical Director
4	Approval of Patients Complaints Policy and Procedure as per model CHP	Clinical and Care Governance Committee	Nurse Director
5	Monitoring and reporting of Patients complaints including trends and learning	Clinical and Care Governance Committee	Nurse Director
6	Achievement of SG targets for reduction in Healthcare Associated Infection (HAI) rates	Clinical Care Governance Committee and onwards to Board	Medical Director

Table 5.2 Staff Governance			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Staff Governance Framework	Staff Governance Committee	Director of Human Resources and Organisational Development
2	Monitoring of Staff Governance Framework	Area Partnership Forum onward to Staff Governance Committee	Director of Human Resources and Organisational Development
3	Workforce Strategy/Workforce Plan	Staff Governance Committee	Director of Human Resources and Organisational Development
4	Dignity at Work	Staff Governance Committee	Director of Human Resources and Organisational Development
5	Staff elements of Equality legislation.	Staff Governance Committee with reference to Public Health Committee re overall Equality Scheme duty	Director of Human Resources and Organisational Development
6	Monitoring of Whistleblowing Policy	Staff Governance Committee	Head of Corporate Governance and Administration
7	Operation of Whistleblowing Policy	Area Partnership Forum	Head of Corporate Governance and Administration
8	Safe Staffing Legislation	Staff Governance Committee referring to Clinical Governance Committee	Director of Human Resources and Organisational Development/ Nurse Director

Table 5.3 Risk Management			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Risk Management Strategy	Risk management Steering Group onwards to Audit and Risk Committee	Chief Executive
2	Health & Safety	Health & Safety Committee onward to CMT and Staff Governance Committee	Director of Human Resources and Organisational Development/ Chief Executive
3	Health & Safety Prosecutions	CMT	Chief Executive where CLO advice not acted on; Nominated Director where CLO advice acted on
4	Prescribing policies	Area Drug & Therapeutic Committee	Director of Pharmacy
5	Establishment and administration of insurance arrangements		Director of Finance
6	Oversight of Corporate Risk Register	Audit and Risk Committee; relevant risks to Standing Committees for review	Director of Finance

Table 5.4 Health Planning			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Annual Operational Plan	Finance, Planning and Performance Committee onward to Board	Medical Director/ Director of Finance
2	Appraisal of Board Strategy (Moving Forward Together)	Finance, Planning and Performance Committee onward to Board	Medical Director
3	Agreement of IJB Strategic Plans	Finance, Planning and Performance Committee onward to Board	Medical Director
4	Oversight of Regional Planning	Finance, Planning and Performance Committee	Medical Director

Table 5.5 Performance Management			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Approval of Performance Management Framework	Finance, Planning and Performance Committee	Director of Finance
2	Oversight of System wide Performance	Finance, Planning and Performance Committee	Director of Finance
3	Oversight of Acute Services Performance	Acute Services Committee	Chief Operating Officer

Table 5.6 Information Governance			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Oversight of Information Management Systems & Strategy	Audit and Risk Committee	Director of eHealth
2	Board Digital Strategy	Audit and Risk Committee with reference to Clinical Governance Committee in terms of clinical impact	Medical Director/Director of eHealth
3	Data Protection Act	Audit and Risk Committee	Director of eHealth and Director of Finance as SIRO
4	Caldicott Guardian		Director of Public Health supported by the Medical Director
5	Freedom of Information Policy	Audit and Risk Committee	Head of Corporate Governance and Administration
6	Records Management Plan	Audit and Risk Committee and onwards to Board	Director of eHealth

Table 5.7 Communication			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Communication Strategy	CMT and onwards to Board	Director of Corporate Communications
2	Board Annual Report	CMT and onwards to Board	Director of Corporate Communications
3	Communication of and adherence to SFIs and Scheme of Delegation		Director of Finance

Table 5.8 Emergency and Continuity Planning

Line	Area of Responsibility	Committee Approval Required	Officer Responsible
1	Preparation and maintenance of comprehensive Civil Contingency Plan	Audit and Risk Committee and onwards to Board as required	Director of Public Health
2	Preparation and maintenance of Business Continuity Plan	Audit and Risk Committee and onwards to Board as required	Director of Public Health

Table 5.Public Health			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Public Health Strategy	Public Health Committee	Director of Public Health
2	Strategy implementation and Public Health programme	Public Health Committee	Director of Public Health
3	Health Promotion and Education	Public Health Committee	Director of Public Health
4	Equality Scheme as per legislation	Public Health Committee with reference to Staff Governance regarding staffing elements e.g. Equal Play	Director of Public Health

Table 5.10 Other Areas			
Line	**Area of Responsibility**	**Committee Approval Required**	**Officer Responsible**
1	Patient Experience, and Feedback	Clinical Care Governance Committee	Nurse Director
3	SFIs and Scheme of Delegation	Audit and Risk Committee and onwards to Board	Director of Finance
4	Public engagement		Nurse Director

NHS Greater Glasgow and Clyde

Governance Committees Terms of Reference

NHS Greater Glasgow and Clyde
Audit and Risk Committee

Terms of Reference

1. Introduction

1.1 The Audit and Risk Committee (ARC) is established in accordance with NHS Greater Glasgow & Clyde Board Standing Orders and Scheme of Delegation and is a Standing Committee of the NHS Board.

1.2 The Standing Orders for the Proceedings and Business of the NHS Board shall apply, where relevant, to the conduct of business of all Standing Committees of the NHS Board.

1.3 The purpose of the ARC conduct of public business, and the stewardship of funds under its control. In particular, the Committee will seek to provide assurance to the Board that an appropriate system of internal control is in place to ensure that:

- Business is conducted in accordance with law and proper standards governing the NHS and its interface with partner organisations;
- Public money is safeguarded and properly accounted for;
- Financial Statements are prepared timeously, and give a true and fair view of the financial position of the Board for the period in question;
- Reasonable steps are taken to prevent and detect fraud and other irregularities; and
- The Board's overall governance framework, including risk management, which encompasses all areas within the organisation, is robust.

The ARC will support the Board and the Accountable Officer by reviewing the comprehensiveness, reliability and integrity of assurances provided to meet the assurance needs of the Board and Accountable Officer. In this context, assurance is defined as an evaluated opinion, based on evidence gained from review, on the organisation's governance, risk management and internal control framework.

2. Membership

2.1 The Committee shall be appointed by the NHS Board Chair and endorsed by the NHS Board. The ARC will consist of up to 9 Non Executive Directors, and will be supported by the Director of Finance, Chief Executive, and senior managers.

2.2 The Chair of the Board shall not be a member of the Committee, but shall have the right to attend meetings. As the Committee is responsible for overseeing the regularity of expenditure by NHS Greater Glasgow, other Board Members shall also have the right to attend. A schedule of meetings will be published, and those NHS Board members who confirm their intention to attend the meeting will be issued with papers for that meeting.

2.3 At least one member of the ARC should have recent and relevant financial experience.

2.4 Other officers may be invited to attend for all or part of any meeting as and when appropriate.

3. Arrangement for Conduct of Business

3.1 **Chairing the Committee**
The NHS Board Chair will appoint a Committee Chairperson and Vice Chairperson which will be endorsed by the NHS Board. In the event of the Chairperson of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired by the Vice Chairperson.

3.2 **Quorum**
Meetings will be considered quorate when 4 Non Executive Members are present.

3.3 **Voting**
Should a vote need to be taken, only the Members of the Committee shall be allowed to vote, either by show of hands, or a ballot.

3.4 **Frequency of Meetings**
The ARC shall meet a minimum of four times per year. Additional meetings may be arranged at the discretion of the Committee Chair after consulting with the NHS Board Chair, Director of Finance, and Chief Executive.

3.5 **Declarations of Interest**
Declarations of Interest will be a standing agenda item. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as requested at the start of the meeting and shall not participate in the discussions. The Chair will have the authority to request that member to withdraw until the Committee's consideration has been completed.

3.6 All declarations of interest will be minuted.

3.7 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the Committee.

3.8 **Support Arrangements**
The Director of Finance shall be responsible for implementing appropriate arrangements within the organisation to support the effective operation of the Audit and Risk Committee. This will be by way of an executive group which shall provide support to the Audit and Risk Committee by ensuring that reports and relevant matters are being actioned at local level by management. It will also agree which responsible officers should be instructed to attend the Audit and Risk Committee to be responsible for an audit report. These arrangements shall be subject to review, evaluation and approval on an annual basis by the Audit and Risk Committee.

3.9 Administrative support for the Committee will be provided by a member of the Corporate Services Team.

3.10 The administrative support to the Committee will attend to take the minutes of the meeting, maintain a log of actions and a committee agenda forward planner, providing appropriate support to the Chairperson and Committee members.

3.11 The external auditor, internal auditor, Chief Executive and Director of Finance shall normally attend all meetings.

3.12 The external auditor and internal auditor shall have free and confidential access to the Chair of the Audit and Risk Committee.

3.13 The external auditor and internal auditor shall meet on at least one occasion each year with the Committee without the Director of Finance, other Executive Directors or Board staff being present. The Chair shall ensure that an accurate record is made of any conclusion reached as the result of such meeting.

3.14 The Chair may ask any or all of those who normally attend but who are not Members to withdraw to facilitate open and frank discussion of specific matters. The Chair shall ensure that an accurate record is made of any conclusion reached as the result of such discussions.

3.15 The Audit and Risk Committee will provide the Board and the Accountable Officer with an annual report on the Board's system of internal control, timed to support finalisation of the Annual Report and Accounts, including the Governance Statement. This report will include a summary of the Committee's conclusions from the work it has carried out during the year.

4 .0 Remit

4.1 The Committee shall be responsible for monitoring the Board's corporate governance arrangements and system of internal control. This will include the following specific responsibilities.

(i) Corporate Governance, System of Internal Control, Risk Management and Arrangements for the Prevention and Detection of Fraud

1. Overseeing the Board's Governance arrangements, including compliance with the law, Scottish Government Health Directorates guidance or instructions, the Board's Standing Orders, Standing Financial Instructions and Code of Conduct for Staff.
2. Evaluating the adequacy and effectiveness of the internal control environment and providing a statement annually to the Board. This evaluation will be based on the work of, and annual report of, the Internal Auditors on behalf of the committee.
3. Reviewing the assurances given in the Governance Statement. The Audit and Risk Committee may challenge
   - Executives to question whether the scope of their activity delivers the assurance needed by the Board and the Accountable Officer;
   - Whether the assurance given is founded on sufficient, reliable evidence and whether the conclusions are reasonable in the context of the evidence.
4. The Audit and Risk Committee shall be proactive in commissioning assurance work from appropriate sources if it identifies any significant risk, governance or control issue which is not being subjected to adequate review. It shall also seek to ensure that any weaknesses, identified by reviews, are remedied.
5. Oversight and monitoring of the effectiveness of arrangements for the governance of the Board's systems for the management of risk. This includes regular review of the Corporate Risk Register and minutes of Risk Management Steering Group meetings.
6. Seek assurance from other Board committees that appropriate action is being taken to mitigate risk and implement recommendations arising from audits and inspections carried out.
7. Monitoring the effectiveness of arrangements to prevent and detect fraud and to receive regular reports on these arrangements and the levels of detected and suspected fraud.
8. Review its own effectiveness and report the results of that review to the Board and Accountable Officer.
9. Oversight of and monitoring of the Board's systems for information governance receiving minutes and updates from the Information Governance Steering Group.
10. Oversight of claims against the Board, liability and settlement status.

(ii) Standing Orders, Standing Financial Instructions and Other Governance Documentation

1. As required but at least annually, reviewing changes to the Standing Orders, Standing Financial Instructions and other governance documentation including the Fraud Policy and Code of Conduct for Staff and recommend changes for Board approval.
2. Reviewing annually (or as required) the Scheme of Delegation.
3. Examining circumstances when the Board's Standing Orders and Standing Financial Instructions are waived.

(iii) Internal and External Audit

1. Approving the arrangements for securing an internal audit service, as proposed by the Director of Finance to the Chair of the Audit and Risk Committee.
2. Monitoring the delivery of internal audit and the annual performance of external audit.
3. Approving and reviewing internal audit plans, and receiving reports on their subsequent achievement.
4. Reviewing external audit plans, and receiving reports on their subsequent achievement.
5. Monitoring management's response to audit recommendations, and reporting to the Board where necessary.
6. Receiving management letters and reports from the statutory external auditor, and reviewing management's response.
7. Discussing with the external auditor (in the absence of the Executive Directors and other officers where necessary) the annual report, audit scope and any reservations or matters of concern which the external auditor may wish to discuss.
8. Ensuring that the Chief Internal Auditor and External Auditor have unrestricted access to the Chair of the Committee.
9. Ensuring co-ordination between internal and external audit.
10. Receiving and approving the internal auditor's report on the review of property transactions monitoring and reporting the results of this review on behalf of the NHS Board to the Scottish Government Health Directorates in accordance with the NHS Scotland Property Transactions Handbook.

(iv) Annual Accounts

1. Approving changes to accounting policies, and reviewing the Board's Annual Report and Accounts prior to their adoption by the full Board. This includes:
    - Reviewing significant financial reporting issues and judgements made in the preparation of the Annual Accounts;

- Reporting in the Directors' report on the role and responsibilities of the Audit and Risk Committee and the actions taken to discharge those;
- Reviewing unadjusted errors arising from the external audit; and
- Reviewing the schedules of losses and compensations.

2. The Chair of the Audit and Risk Committee (or nominated deputy) should be in attendance at the Board meeting at which the Annual Accounts are approved.

5. Authority

5.1 The ARC is a Standing Committee of the NHS Board.

6. Reporting Arrangements

6.1 The ARC will report to the NHS Board.

6.2 The approved minutes of the ARC will be presented in draft form to the next NHS Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft Minutes will be cleared by the Chair of the ARC the nominated Director of Finance prior to distribution. The final approved minute will be represented to the Board at a later date.

6.3 The Chairperson of the Committee shall draw to the attention of the NHS NHS Board any issues that require escalation or noting.

7.0 Conduct of the Committee

7.1 All members will have due regard to and operate within the NHS Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

7.2 The Committee will participate in an annual review of the Committee's remit and membership, to be submitted to the NHS Board in June of each year, and more frequently if required by the NHS Board.

VERSION CONTROL

Revised September 2016

Revised August 2017

Revised March 2018

Revised June 2019

NHS Greater Glasgow and Clyde

Finance, Planning and Performance Committee

Terms of Reference

1. Introduction

1.1 The Finance, Planning and Performance (FP&P) Committee is established in accordance with NHS Greater Glasgow & Clyde NHS Board Standing Orders and Scheme of Delegation.

1.2 The Finance, Planning and Performance Committee is a Standing Committee of the NHS Board.

1.3 The overall purpose of the Finance Planning and Performance Committee is to provide assurance across the healthcare system regarding finance and performance, ensure alignment across whole system planning and commissioning, and to discharge the delegated responsibility from the NHS Board in respect of asset management.

1.4 The Committee will receive reports, and draft plans for review and response in respect of; Finance, Performance, Asset Management, West of Scotland Regional Planning, National Shared Services, NHS GGC strategic plans (including Moving Forward Together) and Health and Social Care Partnership strategic plans.

2. Membership

2.1 The Committee shall be appointed by the NHS Board Chair and endorsed by the NHS Board. The FP&P Committee will consist of 14 Non Executive Directors, and will be supported by the Chief Executive, Executive Directors, Health and Social Care Partnership (HSCP) Chief Officers and relevant senior managers.

2.2 The Non Executive Directors will be mainly drawn from the NHS Board's statutory committee chairs, leads on Integration Joint Boards (IJBs) and will also include the Employee Director.

2.2 Other officers may be invited to attend for all or part of any meeting as and

when appropriate.

3. Arrangement for Conduct of Business

3.1 Chairing the Committee

The NHS Board Chair will appoint a Committee Chairperson and Vice Chairperson which will be endorsed by the Board. In the event of the Chairperson of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired by the Vice Chairperson.

3.2 Quorum

Meetings will be considered quorate when 7 Non Executive Members are present.

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 a show of hands, or a ballot.

3.4 Frequency of Meetings

The Finance, Planning and Performance Committee shall meet six times per year. Additional meetings may be arranged at the discretion of the Committee Chair after consulting with the NHS Board Chairman and Chief Executive.

3.5 Declarations of Interest

Declarations of Interest will be a standing agenda item. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as requested at the start of the meeting and shall not participate in the discussions. The Chair will have the authority to request that member to withdraw until the Committee's consideration has been completed.

3.6 All declarations of interest will be minuted.

3.7 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the committee.

3.8 Administrative Support

3.9 Administrative support for the Committee will be provided by a member of the Corporate Services Team.

3.10 The administrative support to the Committee will attend to take the minutes of the meeting, maintain a log of actions and a committee agenda forward planner, providing appropriate support to the Chairperson and Committee

members.

4. Remit of the Committee

4.1 The remit of the Finance, Planning and Performance Committee is to scrutinise the following key areas and provide assurance to the NHS Board regarding:

- Whole system strategic planning and performance including oversight of the healthcare services delegated to IJBs;
- Whole system financial planning, including an overview of budgets delegated;
- The Property and Asset Management Strategy and Capital Plans of the NHS Board;
- Robust and effective stakeholder engagement across the planning processes and work programmes;
- Appropriate governance in respect of risks, as allocated to FP&P by the Audit Committee relating *to finance, planning, performance* and *property*, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.

5. Key Duties of the Committee

5.1 The Key Duties of the Finance, Planning and Performance Committee are as follows:

Planning and Commissioning

- To review the development of the NHS Board's Strategic Plans, ensuring that strategic planning objectives are aligned with the NHS Board's overall strategic vision, aims and objectives, and make recommendations to the NHS Board;
- Ensure appropriate inclusion of National and Regional Planning requirements and monitor overall progress with the West of Scotland planning agenda;
- To ensure NHSGGC input, at an appropriate level, to draft IJBs Strategic Plans, and promote consistency and coherence across the system highlighting issues which may impact the delivery of NHS Board aims and objectives. Oversee the NHS Board's required formal responses to consultation by IJBs and make recommendations to the NHS Board;
- To consider the NHS Board's Annual Operational Plan and make recommendations to the NHS Board;
- To maintain oversight of progress with the implementation of the Moving Forward Together Programme; receiving reports from the Programme Board, scrutinising cases for change, receiving assurance on effective engagement, providing support and advise to the Programme Board, and making

recommendations to the NHS Board

- To ensure oversight of the development of national shared services, considering action required and any impacts on the NHS Board and IJBs.

Financial Management

- To review the development of the NHS Board's Financial Strategy over a three year period and the Board's Annual Financial Plan making recommendations to the NHS Board;
- To have oversight and undertake analysis of financial performance across the whole system in order to consider significant issues which may impact adversely on the NHS Board's financial position, including budgets delegated to IJBs;
- To oversee the use of non-recurrent funds and reserves.

Performance Management

- To review the NHS Board Performance Management Framework ensuring it is in line with the National Performance Framework and make recommendations to the NHS Board;
- To review the NHS Board's overall performance and planning objectives, and ensure mechanisms are in place to promote best value, improved efficiency and effectiveness;
- To seek assurance on a rigorous and systematic approach to performance monitoring and reporting across the whole healthcare system to enable more strategic and better informed discussions to take place at the full NHS Board.
- To seek assurance as to the adoption of a risk based approach to performance management through routine review, focussing on areas of corporate concern identified as requiring an additional strategic and collective approach to ensure delivery against whole system performance targets.

Property and Asset Management

To ensure that the Property & Asset Management Strategy is in line with the NHS Board's strategic direction and;

- That the NHS Board's property and assets are developed, and maintained to meet the needs of 21st Century service models
- That developments are supported by affordable and deliverable Business Cases with detailed project implementation plans with key milestones for timely delivery, on budget and to agreed standard
- That the property portfolio of NHSGGC and key activities relating to property

are appropriately progressed and managed within the relevant guidance and legislative framework;

- That there is a robust approach to all major property and land issues and all acquisitions and disposals are in line with the Property Transaction Handbook (PTHB).
- To review the Capital Plan and submit to the NHS Board for approval and oversee the overall development of major schemes over £5m, including approval of capital investment business cases. The committee will also monitor the implications of time slippage and / or cost overrun and will instruct and review the outcome of the post project evaluation.
- To review all Initial Agreements, Outline Business Cases and Full Business Cases and recommend to the NHS Board as appropriate.
- To receive reports on relevant legislation and best practice including the Scottish Capital Investment Manual (SCIM), CEIs, audit reports and other Scottish Government Guidance.

The F&P Committee will receive minutes from the:

- MFT Programme NHS Board
- West of Scotland Regional Planning Group
- Capital/ Property Planning Group

6. Authority

6.1 The Finance & Planning Committee is a Standing Committee of the NHS Board.

7. Reporting Arrangements

7.1 The FP&P Committee will report to the NHS Board.

7.2 The approved minutes of the FP&P Committee will be presented in draft form to the next NHS Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft Minutes will be cleared by the Chair of the Finance, Planning and Performance Committee and the nominated Lead Director prior to distribution. The final approved minute will be represented to the Board at a later date.

7.3 The Chairperson of the Committee shall draw to the attention of the NHS NHS Board any issues that require escalation or noting.

8. Conduct of the Committee

8.1 All members will have due regard to and operate within the NHS Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for

Members.

8.2 The Committee will participate in an annual review of the Committee's remit and membership, to be submitted to the NHS Board in June of each year, and more frequently if required by the NHS Board.

Version Control	
Version 1	May 2019 EV

NHS Greater Glasgow and Clyde

Clinical & Care Governance Committee

Terms of Reference

1. Introduction

1.1 The Clinical & Care Governance Committee (C&CGC) is established in accordance with NHS Greater Glasgow & Clyde Board Standing Orders and Scheme of Delegation and is a Standing Committee of the NHS Board.

1.2 The Standing Orders for the Proceedings and Business of the NHS Board shall apply, where relevant, to the conduct of business of all Standing Committees of the NHS Board.

1.3 The overall purpose of the Clinical & Care Governance Committee is to provide assurance across the whole system regarding clinical and care governance ensuring escalation to the NHS Board.

2. Membership

2.1 The Committee Chair, Vice Chair and members shall be appointed by the NHS Board Chair and endorsed by the NHS Board. The C&CGC & Committee will consist of eight Non Executive Directors, and will be supported by the Chief Executive, Medical Director and Nurse Director, Head of Clinical Governance and other relevant senior managers.

2.2 Other officers may be invited to attend for all or part of any meeting as and when appropriate.

3. Arrangement for Conduct of Business

3.1 **Chairing the Committee**

In the event of the Chair of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired by the Vice Chair.

3.2 **Quorum**

Meetings will be considered quorate when four Members are present.

3.3 **Voting**

Should a vote need to be taken, only the Members of the Committee shall be allowed to vote, either by show of hands, or a ballot.

3.4 **Frequency of meetings**

The Clinical & Care Governance Committee shall meet four times per year. Additional meetings may be arranged at the discretion of the Committee Chair after consulting with the NHS Board Chair and Chief Executive.

3.5 **Declaration of Interests**

Declarations of Interest will be a standing agenda item. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as requested at the start of the meeting and shall not participate in the discussions. The Chair will have the authority to request that member to withdraw until the Committee's consideration has been completed.

3.6 All declarations of interest will be minuted.

3.7 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the Committee.

3.8 **Administrative Support**

3.9 Administrative support for the Committee will be provided by a member of the Corporate Services Team.

3.10 The administrative support to the Committee will attend to take the minutes of the meeting, maintain a log of actions and a committee agenda forward planner, providing appropriate support to the Chairperson and Committee members.

4. Remit of the Committee

4.1 The remit of the C&CGC is to scrutinise and provide assurance to the NHS Board regarding the following key areas:

- Development and oversight of the NHS Board's Clinical Governance Strategy and Quality Strategy;
- Ensuring clinical and care governance arrangements are effective in improving and monitoring the safety and quality of clinical care;
- Ensure oversight of a person centred care and feedback reflecting learning;
- That NHS GGC fulfils its statutory obligations relating the Board's Duty of Quality – including Duty of Candour;
- To provide advice and assurance to the NHS Board that clinical service

proposals i.e. in respect of Moving Forward Together and other relevant strategies, are consistent with the continued provision of safe and effective care;

- That the implications of the Safe Staffing legislation, as identified through the Staff Governance Committee, are considered, and any impact on clinical care escalated;
- Appropriate governance in respect of risks, as allocated to the CCGC by the Audit Committee relating *to clinical care and safety* reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.
- Promotion of clinical leadership and staff engagement in the improvement and monitoring of the quality of clinical care.

5. Key Duties of the Committee

5.1 The key duties of the CC&GC are to receive and review reports and, as appropriate, seek direct feedback from staff concerning:

- Implementation of a Clinical Governance Strategy/supporting Framework ensuring a robust system assurance is in place across the whole system;
- Implementation of the Quality Strategy and monitoring delivery of the agreed priorities;
- Ensure learning is shared and best practice highlighted;
- Relevant data and trends in patient safety, experience and outcomes, including feedback from patient safety walkrounds, to provide assurance to the NHS Board on standards of quality in clinical care;
- Compliance with relevant regulatory requirements and national clinical standards;
- The processes within NHSGGC to ensure that appropriate action is taken in response to *adverse clinical incidents*, *complaints* and *SPSO feedback*, that learning is disseminated (internally or externally if appropriate) and lessons are applied to provide for sustainable improvement in the quality of care;
- Quality and safety related externally led inquiries or reviews and regulatory inspections, including the provision of external or public assurance with regard to the preparation and implementation of associated action plans; and
- Promotion of public transparency including the provision of the Annual Clinical Governance report, the reporting of any situation that may impact the quality of patient care, involvement of patients and public in clinical governance processes and compliance with the requirements of the Duty of Candour.

- Review the Complaints Handling Procedure as per national guidance and make recommendations to the NHS Board as required.

- Oversee the West of Scotland Research Ethics Service responsibilities in managing the West of Scotland Research Ethics Committees through the receipt of an Annual Report.

The C&CGC will receive minutes/reports from the:

- Board Clinical Governance Forum

6. Authority

6.1 The Clinical & Care Governance Committee is a Standing Committee of the NHS Board.

7. Reporting Arrangements

7.1 The C&CGC will report to the NHS Board.

7.2 The approved minutes of the C&CGC will be presented in draft form to the next NHS Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft Minutes will be cleared by the Chair of the C&CGC and the nominated Lead Director prior to distribution. The final approved minute will be represented to the Board at a later date.

7.3 The Chairperson of the Committee shall routinely draw to the attention of the NHS Board any issues that require escalation or noting.

8. Conduct of the Committee

8.1 All members will have due regard to and operate within the Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

8.2 The Committee will participate in an annual review of the Committee's remit and membership, to be submitted to the NHS Board for approval.

Version Control	
Version 1	May 2019

NHS Greater Glasgow and Clyde

Staff Governance Committee

Terms of Reference

1. Introduction

1.1 The Staff Governance Committee (SGC) is established in accordance with NHS Greater Glasgow & Clyde Board Standing Orders and Scheme of Delegation and is a Standing Committee of the NHS Board.

1.2 The Standing Orders for the Proceedings and Business of the NHS Board shall apply, where relevant, to the conduct of business of all Standing Committees of the NHS Board.

1.3 The purpose of the SGC is to provide assurance to the Board that NHS Greater Glasgow and Clyde meets its obligations in relation to staff governance under the National Health Service Reform (Scotland) Act 2004 and the Staff Governance Standard ('the Standard'). The Staff Governance Committee is a Standing Committee of the NHS Board.

1.4 In particular, the SGC will seek to ensure that staff governance mechanisms are in place that take responsibility for performance against the Staff Governance Standard and are accountable for oversight of progress towards achievement of the Standard.

2. Membership

2.1 The Committee membership shall be appointed by the NHS Board Chair and endorsed by the Board, and will be given a remit, including providing advice to the Board on the conduct of its business.

2.2 The Board Chair shall appoint up to eight Non-Executive Members of the NHS Board, which shall include the Employee Director. The Committee will be co-chaired by the Employee Director and a Non-Executive Director appointed from within the membership of the Committee.

2.3 Members of the Area Partnership Forum listed below shall be ex-officio Members of the Committee (without voting rights):

- Director of Human Resources and Organisational Development
- Depute Director of Human Resources
- Head of People & Change as appropriate
- Chief Officer (representing HSCPs)
- Chief Operating Officer (representing Acute)
- Area Partnership Forum Staff Side Secretaries (2)
- Area Partnership Forum Acute Division Joint Trade Union representative
- Area Partnership Forum HSCPs Joint Trade Union representatives one representing Glasgow City HSCP and one to represent the non city partnerships

The SGC may invite to attend other senior managers and trade union representatives e.g. Head of Health & Safety, Head of Inequalities.

3. Arrangement for Conduct of Business

3.1 Chairing the Committee

The NHS Board Chair shall appoint two co-chairs, one of whom will be the Employee Director. In the event of a co-chair of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired solely by the other co-chair. In the absence of both co-chairs, the meeting shall be chaired by another voting member of the committee as agreed by the voting membership present.

3.2 Quorum

At least four Non Executive Members of the Committee must be present in order to form a quorum.

3.3 Voting

Should a vote need to be taken, only the voting Members of the Committee shall be allowed to vote. Such a vote shall be either by show of hands, or by ballot.

3.4 Frequency of Meetings

There should be a minimum of four meetings per annum. Additional meetings may be arranged at the discretion of the Committee Co-Chairs after consulting with the NHS Board Chairman and Chief Executive.

3.5 Declarations of Interest

If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest at the start of the meeting and depending on the significance of the interest may not thereafter participate in the discussions. The Chair of the meeting will have the power to request that member to

withdraw until the Committee's consideration of the relevant matter has been completed.

3.6 All declarations of interest will be minuted.

3.7 **Administrative Support**

Administrative support for the Committee will be provided by a member of the HR Team supported by the Corporate Services Team.

3.8 The administrative support to the SGC will attend to take the minutes of the meeting, maintain a log of actions and a Committee forward planner, provide appropriate support to the Co-Chairs and Committee, and support the preparation of an Annual Report on the work of the Committee for presentation to the Board.

4. Remit of the Committee

4.1 The SGC shall support the creation of a culture within the health system, where the delivery of the highest possible standards of staff management is understood to be the responsibility of everyone working within NHS Greater Glasgow and Clyde and this is built upon partnership and co-operation.

5. Key Duties of the Committee

5.1 The Committee shall act for the Board to oversee the commissioning of structures and process which ensure that delivery against the Staff Governance Standard is being achieved and ensure staff are:

- Well informed;
- Appropriately trained and developed;
- Involved in decisions;
- Treated fairly and consistently, with dignity and respect, in an environment where diversity is valued; and,
- Provided with a continuously improving and safe working environment, promoting the health and wellbeing of staff, patients and the wider community.

5.2 The SGC shall monitor and evaluate strategies and implementation plans relating to people management.

5.3 The SGC shall perform a governance function for the Board's Health and Safety Forum, the Board wide Revalidation Group, Medical Staff Governance & Workforce Information Group, and any other relevant standing or ad hoc groups as agreed by the NHS Board.

5.4 The SGC shall be authorised by the Board to approve any policy amendment, resource submission to the Director of Finance to achieve the Staff

Governance Standard.

5.5 The SGC shall take responsibility for oversight of the timely submission of all the staff governance data required for national monitoring arrangements.

5.6 The SGC shall provide staff governance information for the statement of internal control.

5.7 The SGC shall provide assurance that systems and procedures are in place through the local Remuneration Committee to manage senior manager pay as set out in MEL(1993)114 (amended).

5.8 The SGC shall ensure appropriate governance in respect of risks, as allocated to the Committee by the Audit and Risk Committee, in respect of staff, reviewing risk identification, assessment and mitigation, in line with the NHS Board's risk appetite, and agreeing appropriate escalation.

5.9 The SGC will oversee the implementation of key aspects of Equality legislation in respect of staff e.g. Equal Pay, Equality and Diversity Training

5.10 The SGC will seek assurance regarding the implementation of the Safer Staffing Regulations.

6. Authority

6.1 The SGC is a Standing Committee of the NHS Board.

7. Reporting Arrangements

7.1 The SGC will report to the NHS Board.

7.2 The approved minutes of the SGC will be presented in draft form to the next NHS Board meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft minutes will be cleared by the Co-Chairs of the Committee and the Director of Human Resources and Organisational Development prior to distribution. The final approved minute will be presented to the Board at a later date.

7.3 The Co-Chairs of the SGC shall draw to the attention of the NHS Board any issues that require escalation.

8. Conduct of the Committee

8.1 All members will have due regard to and operate within the Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

8.2 The SGC will participate in an annual review of the Committee's remit

and membership, to be submitted to the NHS Board in June of each year, and more frequently if required by the NHS Board. Note, this is in addition to the report noted in para 3.8 which fulfils a separate function.

Version Control	
Version 1	June 2019 GF

NHS Greater Glasgow and Clyde

Remuneration Committee

Terms of Reference

1. Introduction

1.1 The Remuneration Committee is a Sub Committee of the Staff Governance Committee, which is a formal Standing Committee of the Board.

1.2 The Remuneration Committee will ensure the application and implementation of fair and equitable systems for pay and for performance management on behalf of the Board as determined by Scottish Ministers and the Scottish Government Health Directorate.

2. Membership

2.1 The membership of the Remuneration Committee will be:

- NHS Board Chair and up to 7 Non Executive Members (including the Vice Chair and Employee Director)

2.2 Members shall be appointed by the NHS Board Chair and endorsed by the the NHS Board.

2.3 The Board Chief Executive and Director of Human Resources and Organisational Development will be in attendance to provide advice and support.

3. Arrangement for Conduct of Business

3.1 **Chairing the Committee**

The NHS Board Chair will Chair the Committee. In the event of the Chairperson of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired by the Vice Chairperson of the NHS Board.

3.2 **Quorum**

Meetings will be considered quorate when 3 Non Executive Members are present (one of whom may be the Chair).

3.3 **Frequency of Meetings**

The Committee shall meet a minimum of twice per annum. Additional meetings may be arranged at the discretion of the Committee Chair.

3.4 **Administrative Support**

The Head of Corporate Governance and Administration and (or authorised nominee) will provide secretariat services.

4. Remit

4.1 The remit of the Remuneration Committee is to ensure the application and implementation of fair and equitable pay systems on behalf of the Board, as determined by Ministers and the Scottish Government, and described in MEL (1993) 114 and subsequent amendments.

4.2 The Remuneration Committee shall provide assurance that systems and procedures are in place to manage senior manager pay as set out in MEL(1993)114 and subsequent amendments, so that overarching staff governance responsibilities can be discharged.

5. Key Duties of the Committee

5.1 The remit of the Remuneration Committee is to scrutinise the following key areas and provide assurance to the Staff Governance Committee regarding:

5.2 In accordance with Scottish Government Health Directorate guidance, determine and regularly review the pay arrangements for the NHS Board's Senior Managers whose posts are part of the Executive Cohort (national pay grades – D to I) and Senior Management Cohort (national pay grades – A to C) and ensure that an effective system of performance management for these groups is in operation; as well determine and regularly review the remuneration arrangements for Non-Executive Members of the NHS Board.

5.3 Ensure implementation of the pay and terms and conditions of employment of the Executive and Senior Management cohorts of the NHS Board as set out in Ministerial Directions, including job descriptions, job evaluation, terms of employment, basic pay and performance related pay increases.

5.4 Ensure implementation and maintenance of the electronic performance

management system - Turas Appraisal for Executive and Senior Management Cohorts for the forthcoming year.

5.5 Ensure that the performance of the Executive and Senior Management Cohorts is rigorously assessed against agreed objectives and act as reviewer for the Chief Executive; objectives may, by agreement with the individual being assessed, be revised in the course of the mid-year review to reflect unforeseen changes in circumstances.

5.6 Review any temporary responsibility allowances of the Executive and Senior Management cohort.

5.7 Agree any severance Policies/Procedures in respect of all staff including Executive and Senior Managers, e.g. premature retirals under the NHS Superannuation Scheme.

5.8 Approve any new posts within the Executive cohort (national pay grades – D to I).

5.9 Approve any annual pay uplifts to any staff group out with AFC during transition periods following any TUPE agreements.

5.10 Approve the annual process for the awarding of Discretionary Points to relevant clinical staff.

5.11 Undertake a governance role in respect of reviewing and providing an oversight to national pay and performance matters and their application and implementation within NHSGGC.

5. Authority

5.1 The Remuneration Committee is a Sub Committee of the Staff Governance Committee, which is a formal Standing Committee of the Board.

6. Reporting Arrangements

6.1 To ensure that the Staff Governance Committee is fully apprised of the work of the Remuneration Committee, the Employee Director will present a summary of key issues discussed and processes applied, the terms of the which shall be agreed with the Chair of the Committee.

7. Conduct of the Committee

7.1 All members will have due regard to and operate within the NHS Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

Version Control	
Version 1	June 2019 GM

NHS Greater Glasgow and Clyde

Acute Services Committee

Terms of Reference

1. Introduction

1.1 The Acute Services Committee (ASC) is established in accordance with NHS Greater Glasgow & Clyde Board Standing Orders and Scheme of Delegation and is a Standing Committee of the NHS Board.

1.2 The Standing Orders for the Proceedings and Business of the NHS Board shall apply, where relevant, to the conduct of business of all Standing Committees of the NHS Board.

1.3 The purpose of the ASC is to oversee acute services across Greater Glasgow and Clyde (GGC) and provide assurance to the NHS Board regarding performance, financial governance and quality of acute care.

2. Membership

2.1 The Committee shall be appointed by the NHS Board Chair and be endorsed by the NHS Board. The ASC will consist of 11 Non Executive Directors, and will be supported by the Chief Executive, Chief Operating Office and relevant Executive Directors and senior managers.

2.2 Other officers may be invited to attend for all or part of any meeting as and when appropriate.

3. Arrangement for Conduct of Business

3.1 **Chairing the Committee**

The NHS Board Chair will appoint a Committee Chairperson and Vice Chairperson which will be endorsed by the NHS Board. In the event of the Chairperson of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired by the Vice Chairperson.

3.2 **Quorum**

Meetings will be considered quorate when five Non Executive Members are present.

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.

3.4 **Frequency of Meetings**

The ASC shall meet a minimum of four times per year. Additional meetings may be arranged at the discretion of the Committee Chair after consulting with the NHS Board Chair, Chief Executive and Chief Operating Officer.

3.5 **Declarations of Interest**

Declarations of Interest will be a standing agenda item. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest as requested at the start of the meeting and shall not participate in the discussions. The Chair will have the authority to request that member to withdraw until the Committee's consideration has been completed.

3.6 All declarations of interest will be minuted.

3.7 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the Committee.

3.8 **Administrative Support**

3.9 Administrative support for the Committee will be provided by a member of the Corporate Services Team

3.10 The administrative support to the Committee will attend to take the minutes of the meeting, maintain a log of actions and a committee agenda forward planner, providing appropriate support to the Chairperson and Committee members.

4. Remit of the Committee

4.1 The remit of the ASC is to scrutinise the following key areas and provide assurance to the NHS Board regarding:

- Performance management and improvement across all aspects of the Acute Service's consistent with Corporate Objectives, relevant Annual Operating Plan targets, locally-based targets and priorities;

- The efficiency, effectiveness and quality of services delivered to patients in acute care;

- Acute Services Financial Planning and Management;

- Whether current or developing Acute service proposals i.e. in respect of Moving Forward Together and other relevant strategies, are consistent with the continued provision of safe and effective acute care;

- Appropriate governance in respect of risks, as allocated to the ASC by the Audit Committee relating to aspects of Acute Services, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agreeing appropriate escalation.

5. Key Duties of the Committee

5.1 The key duties of the ASC are to receive and review reports and, as appropriate, seek direct feedback from staff in respect of:

Performance Management

- Ensuring a co-ordinated approach to the management of performance across acute services scrutinising areas of challenge, highlighting risk and seeking remedial action;
- Developing the Acute Services aspects of the Annual Operational Plan and oversight of implementation;
- Highlighting positive performance and sharing learning on improvement;
- Considering relevant extracts from the Corporate Risk Register, reviewing risk identification, assessment and mitigation in line with the NHS Board's risk appetite and agree appropriate escalation as required.

Resources

- Monitoring in-year financial performance of revenue resources within Acute Services at agreed frequency of reporting and where necessary, exception reporting.
- Monitoring in-year financial performance of capital resources within Acute Services at agreed frequency of reporting and where necessary, exception reporting.
- Reflecting on the role of the Finance Planning & Performance Committee in the overall monitoring of the Board's financial position across the whole system.

Quality

- Ensuring an integrated approach is taken to delivery of priorities within the Quality Strategy in respect of acute care ensuring efficiency and effectiveness

in service provision;

- Seeking assurance that systems for monitoring and development are in place within Acute Services and which ensures that clinical governance and clinical risk management arrangements are working effectively to safeguard and improve the quality of clinical care referring to the Clinical Care Governance Committee as required;
- Reviewing, as relevant to acute services, the Clinical Governance Strategy and Quality Strategy and respective implementation plans;
- Monitoring Acute Services activities in connection with the person-centeredness approach and oversee patient experience initiatives, complaints/feedback arrangements and monitoring of SPSO recommendations within Acute.

Capital Projects

- By exception, receive reports on Acute Capital schemes and monitor the impact on service delivery of any major issues with these schemes and any delays;
- Providing advice to the Finance, Planning & Performance Committee in respect of acute services on business cases to be submitted to SGHD for approval (usually above £5m), acknowledging it is for the Finance, Planning & Performance Committee to approve such business cases.

6. Authority

6.1 The Acute Services Committee is a Standing Committee of the NHS Board.

7. Reporting Arrangements

7.1 The Acute Services Committee will report to the NHS Board

7.2 The approved minutes of the ASC will be presented in draft form to the next NHS Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft Minutes will be cleared by the Chair of the ASC and the nominated Chief Operating Officer prior to distribution. The final approved minute will be represented to the Board at a later date.

7.3 The Chair of the Committee shall draw to the attention of the NHS Board any issues that require escalation.

8. Conduct of the Committee

8.1 All members will have due regard to and operate within the Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

8.2 The Committee will participate in an annual review of the Committee's remit and membership, to be submitted to the NHS Board in June of each year, and more frequently if required by the NHS Board.

Version Control	
Version 1	June 2019

NHS GREATER GLASGOW & CLYDE

PUBLIC HEALTH COMMITTEE

Terms of Reference

1. Introduction

1.1 The Public Health Committee is established in accordance with NHS Greater Glasgow & Clyde Board Standing Orders and Scheme of Delegation.

1.2 The Public Health Committee is a Standing Committee of the NHS Board.

1.3 The overall purpose of the Public Health Committee is to ensure a dedicated focus on public health across the whole system, working in partnership to promote public health priorities and provide advice and assurance to the NHS Board.

2.0 Membership

2.1 The Committee shall be appointed by the NHS Board Chair and endorsed by the Board, and will consist of up to six Non-Executive Members and supported by the following eight Professional Advisors, who shall be ex-officio Members of the Committee (without voting rights), as follows -

- Director of Public Health;
- Head of Health Improvement;
- Two Consultants in Public Health Medicine;
- Two HSCP Chief Officers;
- Director - Glasgow Centre for Population Health; and
- Representative of Health Scotland.

The Committee will be supported by the Director of Public Health, and other Executive Directors as appropriate. Other Non-Executives will also receive a set of papers separately, for their information.

2.2 Other officers may be invited to attend for all or part of any meeting as and when appropriate.

3.0 Arrangements for the Conduct of Business

3.1 Chairing the Committee

The NHS Board Chair shall appoint a Chair and Vice Chair. In the event of the Chair of the Committee being unable to attend for all or part of the meeting, the meeting will be chaired by the Vice Chair.

3.2 Quorum

Meetings will be considered quorate when three Non-Executive Members are present.

3.3 Voting

Should a vote need to be taken, only the Members of the Committee shall be allowed to vote, either by show of hands, or a ballot.

3.4 Frequency of meetings

The Public Health Committee shall meet four times per year. Additional meetings may be arranged at the discretion of the Committee Chair after consulting with the NHS Board Chair and Chief Executive.

3.5 Declaration of Interests

Declarations of interest will be a standing agenda item. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, he/she will declare that interest at the start of the meeting and depending on the significance of the interest may not thereafter participate in the discussions. The Chair will have the power to request that member to withdraw until the Committee's consideration has been completed.

3.6 All declarations of interest will be minuted.

3.7 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the Committee.

3.8 Administrative Support

3.9 Administrative support for the Committee will be provided by a member of the Corporate Services Team.

3.10 The administrative support to the Committee will attend to take the minutes of the meeting, maintain a log of actions and a Committee forward planner, provide appropriate support to the Co-Chairs and Committee, and support the preparation of an Annual Report on the work of the Committee for presentation to the Board.

4.0 Remit of the Committee

4.1 The remit of the Public Health Committee is to promote public health and oversee population health activities with regular feedback to the full Board to ensure that the Board develops a long term vision and strategy for public health.

5.0 The Key Duties of the Public Health Committee are as follows:

- To consider the public health priorities for NHS Greater Glasgow and Clyde;
- To review the application and monitor the Strategic Plan for Public Health – Turning the Tide, through regular progress reports and review of intermediate measures and long term outcomes making recommendations to the NHS Board;
- To ensure that public health strategic planning objectives are part of the Board's overall objectives, strategic vision and direction;
- To support the Board in taking a long term strategic approach to the health of the population;
- To review the development of the Board's Public Health Directorate's Annual Work-plan across the three domains of Health Protection, Health Improvement and improving the quality of Health Services;
- To undertake scrutiny of individual topics/projects/work-streams to promote the health of the population, including NHSGGC staff;
- To oversee the funding allocated to public health activities by the Board;
- To support the Directorate of Public Health in its advocacy role with stakeholders, partners, national bodies and Governments in promoting health;
- To provide the Board members who are part of IJBs with information and evidence to promote public health;
- To ensure appropriate links to other key work of the Board such as Realistic Medicine, Clinical Services Strategy and Child Health Services;
- To oversee the adherence to Equality legislation referring specific staffing elements e.g. Equal Pay, to the Staff Governance Committee;
- To oversee the requirements of legislation in respect of child poverty making recommendations to the NHS Board.

6.0 Authority

6.1 The Public Health Committee is a Standing Committee of the NHS Board.

7.0 Reporting Arrangements

7.1 The Public Health Committee will report to the NHS Board and submit an Annual Report on its activities to the NHS Board.

7.2 The approved minutes of the Public Health Committee will be presented in draft form to the next NHS Board meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft minutes will be cleared by the Chair of the Public Health Committee and the nominated lead Director prior to distribution. The final approved minute will be presented to the Board at a later date.

7.3 The Chair of the Committee shall draw to the attention of the NHS Board any issues that require escalation.

8.0 Conduct of the committee

8.1 All members will have due regard to and operate within the Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

8.2 The Committee will participate in an annual review of the Committee's remit and membership, to be submitted to the NHS Board in June of each year, and more frequently if required by the NHS Board. Note, this is over and above the Annual Report noted in para 7.1 which serves a different purpose.

Version Control	
Version 1	June 2019 GF

NHS Greater Glasgow and Clyde

Area Clinical Forum

Terms of Reference

1. Introduction

1.1 The Area Clinical Forum is constituted under "Rebuilding our National Health Service" - A Change Programme for Implementing "Our National Health, Plan for Action, A Plan for Change", which emphasised that NHS Boards should both:-

- Draw on the full range of professional skills and expertise in their area for advice on clinical matters both locally and on national policy issues;
- Promote efficient and effective systems - encouraging the active involvement of all clinicians from across their local NHS system in the decision-making process to support the NHS Board in the conduct of its business.

1.2 The Forum will be called NHS Greater Glasgow and Clyde Area Clinical Forum.

2. Membership

2.1 The Area Clinical Forum will comprise the Chairs and Vice Chairs (or relevant Deputy) of the *statutory* Area Professional Committees as follows:-

- Medical
- Dental
- Nursing and Midwifery
- Pharmaceutical
- Optometric
- Area Allied Professionals and Healthcare Scientists
- and the Chair and Vice Chair (or relevant Deputy) of the Area Professional Committees as follows:-
- Psychology

2.2 **Persons in Attendance**

Persons other than Members may be invited to attend a meeting(s) for discussion of specific items at the request of the Chair or Secretary. That person will be allowed to take part in the discussion but not have a vote. NHS Greater Glasgow and Clyde Board's Chief Executive, Medical Director, Director of Public Health, Pharmaceutical Adviser, Nurse Adviser and Consultant in Dental Public Health shall be regular attenders at meetings of the Area Clinical Forum.

A Chief Officer of a Health and Social Care Partnership will be invited to attend meetings of the Forum.

3. Arrangement for Conduct of Business

3.1 Chairing the Forum

3.2 The Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. The Forum's choice of Chair will be notified to the NHS Board Chair. Selection of the Chair will be an open process, and all Members may put themselves forward as candidates for the position. If more than one person puts themselves forward an election will be held by secret ballot.

3.3 The Chair of the Area Clinical Forum will, subject to formal appointment by the Cabinet Secretary for Health and Wellbeing, serve as a Non-Executive Director of NHS Greater Glasgow and Clyde.

3.4 Membership of NHS Greater Glasgow and Clyde is specific to the office rather than to the person. The normal term of appointment for Board Members is for a period up to four years. Appointments may be renewed, subject to Ministerial approval.

3.5 Where the Members of the Area Clinical Forum choose to replace the Chair before the expiry of their term of appointment as a Member of NHS Greater Glasgow and Clyde, the new Chair will have to be formally nominated to the Cabinet Secretary as a Member of NHS Greater Glasgow and Clyde Board for a decision of formal appoint to the Board.

3.6 In the same way, if Board Membership expires and is not renewed, the individual must resign as Chair of the Area Clinical Forum, but may continue as a Member of the Forum.

3.7 Vice Chair

3.8 A Vice Chair of the Area Clinical Forum will be chosen by the Members of the Forum from among their number. Selection of the Vice Chair of the Forum will be an open process and all Members may put themselves forward as candidates for the position. If more than one person puts themself forward an election will be held by secret ballot.

3.9 The Vice Chair will deputise, as appropriate, for the Chair, but where this involves participation in the business of NHS Greater Glasgow and Clyde, they will not be functioning as a Non-Executive Member.

3.10 The Vice Chair will serve for a period of up to four years.

3.11 **Officers of the Forum**

The Term of Office for Members will normally be up to four years. Individuals shall cease to be Members of the Area Clinical Forum on ceasing to be Chair/Vice Chair of their Professional Committee.

3.12 **Quorum**

A quorum of the Forum will be representation from at least four of the constituent subcommittees. In the event that the Chair and Vice Chair are both absent, the Members present shall elect from those in attendance, a person to act as Chair for the meeting.

3.13 **Frequency of Meetings**

3.14 The Area Clinical Forum will meet at least four times each year. This can be varied at the discretion of the Chairman.

3.15 The Forum has the right to alter or vary these arrangements to cover holiday months or other circumstances.

3.16 **Declarations of Interest**

Declarations of interest will be a standing agenda item. If any member has an interest, pecuniary or otherwise, in any matter and is present at the meeting at which the matter is under discussion, they will declare that interest at the start of the meeting and depending on the significance of the interest may not thereafter participate in the discussions. The Chair will have the authority to request that member to withdraw until the Forum's consideration has been completed.

3.17 All declarations of interest will be minuted.

3.18 Any actions taken outside the meeting will be reported and minuted at the next available meeting of the Forum.

3.19 **Administrative Support**

Administrative support to the Area Clinical Forum will be provided by a member of the Corporate Services Team.

3.20 The Administrative Support to the Forum will attend to take the minutes of the

meeting, maintain a log of actions and a Forum agenda forward planner, providing appropriate support to the Chairperson and Forum members.

3.21 Alterations to the Constitution and Standing Orders

3.22 Alterations to the Constitution and Standing Orders may be recommended at any meeting of the Forum provided a Notice of the proposed alteration is circulated with the Notice of the Meeting and that the proposal is seconded and supported by two thirds of the Members present and voting at the meeting.

Any alterations must be submitted to NHS Greater Glasgow and Clyde Board for approval as part of the annual review of Corporate Governance before the change is enforceable.

3.23 **Guest Speakers**

The Forum may invite guest speakers who it considers may have particular contribution to the work of the Forum to attend meetings.

4. Remit of the Forum

4.1 To represent the multi-professional view of the advisory structures for medical, dental, nursing and midwifery, pharmaceutical, optometric, allied health professionals, healthcare scientists, psychology and community health partnerships to NHS Greater Glasgow and Clyde ensuring the involvement of all the professions across the local NHS system in the decision-making process.

5. Key Duties of the Forum

5.1 The core functions of the Area Clinical Forum will be to support the work of NHS Greater Glasgow and Clyde by:-

- Providing NHS Greater Glasgow and Clyde with a clinical perspective on the development of the Local Health Plan and the Board's strategic objectives by, through the ACF Chair, being fully engaged in NHS Board business.

- Reviewing the business of the Area Professional Committees to promote a co-ordinated approach on clinical matters among the different professions and within the component parts of NHS Greater Glasgow and Clyde;

- Promoting work on service design, redesign and development priorities and playing an active role in advising NHS Greater Glasgow and Clyde on potential service improvement;

- Sharing best practice among the different professionals and actively promoting multi-disciplinary working - in both health care and health improvement;

- Engage and communicate widely with local clinicians and other professionals, with a view to encouraging broader participation in the work of the Area Professional Committees to ensure that local strategic and corporate developments fully reflect clinical service delivery;

5.2 At the request of NHS Greater Glasgow and Clyde, the Area Clinical Forum may also be called upon to perform one or more of the following functions:-

- Investigate and take forward particular issues on which clinical input is required on behalf of the Board where there is particular need for multi-disciplinary advice.

- Advise NHS Greater Glasgow and Clyde of the impact of national policies on the integration of services, both within the local NHS systems and across health and social care.

5.3 The Area Clinical Forum will review its functions periodically, in collaboration with NHS Greater Glasgow and Clyde to ensure that they continue to fit local priorities and developments.

6. Authority

6.1 The Area Clinical Forum is a Standing Committee of the NHS Board.

7. Reporting Arrangements

7.1 The Area Clinical Forum will report to the NHS Board and submit an Annual Report on its activities to the NHS Board.

7.2 The approved minutes of the ACF will be presented in draft form to the next NHS Board Meeting to ensure NHS Board members are aware of issues considered and decisions taken. The draft Minutes will be cleared by the Chair of the Form prior to distribution. The final approved minute will be represented to the Board at a later date.

7.3 The Chair of the Forum shall draw to the attention of the NHS Board any issues that require escalation.

8. Conduct of the Forum

8.1 All members will have due regard to and operate within the Board's Standing Orders, Standing Financial Instructions and the Code of Conduct for Members.

8.2 The Forum will participate in an annual review of the Forum's remit and membership, to be submitted to the NHS Board for approval.

Version Control	
Version 2	June 2019 GM

NHS Greater Glasgow and Clyde

Secretariat and Reporting Templates

OFFICIAL SENSITIVE

Meeting of the xxxxxxxx Committee on
xxxxxx at xxxx in the
Meeting Room, JB Russell House, Gartnavel Royal Hospital,
Glasgow, G12 0XH

AGENDA

1.	**Welcome and Apologies**		
2.	**Declarations(s) of Interest(s)**		
3.	**Minutes of Previous Meeting:** **a) Rolling Action List**		
4.	**Matters Arising**		
	TOPIC		
5.	**Agenda item** **Paper presented by the Director of**	Paper/Verbal/ Presentation	Paper No.19/xx
6.	**Agenda Item** **Paper presented by the Director of**		Paper No. 19/xx
7.	**Agenda Item** **Paper presented by the Director of**		
8.	**Agenda Item** **Paper presented by the Director of**		
9.	**Agenda Item** **Paper presented by the Director of**		
	TOPIC		
10.			
11.			
12.			

13.			
14.			
15.			
TOPIC			
16.			
17.			
18.			
19.			
20.			
ITEMS FOR NOTING			
21.			
22.			
	Date and Time of Next Scheduled Meeting		

OFFICIAL SENSITIVE
DRAFT – TO BE RATIFIED

NHSGG&C(M) 19/xx

Minutes: xx - xx

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
xxxxxxxxxxx
held in the xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
on xxxxxxxxxxxxxxx

PRESENT

xxxxxxxx (in the Chair)

IN ATTENDANCE

Name	..	Title
	..	
	..	
	..	
	..	
	..	
	..	
	..	
	..	

			ACTION BY
01.	**WELCOME AND APOLOGIES**		
	Apologies for absence were intimated on behalf of xxxxxxxxxxxxxxxxxxx. **NOTED**		
02.	**DECLARATIONS OF INTEREST**		
	Xxxxxxxxxxxxxxxxxxxxx **NOTED**		
03.	**MINUTES OF THE MEETING HELD xxxxxxxx**		

	Xxxxxxxxxxxxxxxxxxxx **APPROVED**		
04.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	Xxxxxxxxxxxxx **NOTED/APPROVED/AGREED**		
05.	**AGENDA ITEM**		
	XXXXXXXXXXXXXXXXX **NOTED/APPROVED/AGREED**		
06.	**AGENDA ITEM**		
	XXXXXXXXXXXXXXXXX **NOTED/APPROVED/AGREED**		
07.	**AGENDA ITEM**		
	XXXXXXXXXXXXXXXXX **NOTED/APPROVED/AGREED**		

MATTERS ARISING
Rolling Actions List
Name of Committee

Paper Number 19/xx

Meeting Date:

Ref		Action Required	Owner	Expected Completion Date	Update	Status	
Meeting Date	Minute No					Ongoing	Closed
							✓
							✓
							✓
							✓
							✓
							✓
TOTAL						**0**	**6**

NHS Greater Glasgow & Clyde	
Meeting:	**Board Meeting**
Date of Meeting:	**25th June 2019**
Purpose of Paper:	**Approval/For Noting (delete as appropriate)**
Classification:	**Official Sensitive/Board Official (delete as appropriate)**
Sponsoring Director:	

Paper Title

Recommendation

Purpose of Paper

Key Issues to be considered

Any Patient Safety /Patient Experience Issues

Any Financial Implications from this Paper

Any Staffing Implications from this Paper

Any Equality Implications from this Paper

Any Health Inequalities Implications from this Paper

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.

Highlight the Corporate Plan priorities to which your paper relates

Author
Tel No
Date

GREATER GLASGOW AND CLYDE NHS BOARD

ANNUAL REPORT OF XXXX GOVERNANCE COMMITTEE 2018/2019

1. PURPOSE

In order to assist the Board in conducting a regular review of the effectiveness of the systems of internal control, Standing Orders require that this Standing Committee submits an annual report to the Board. This report is submitted in fulfilment of this requirement.

2. xxxxxx GOVERNANCE COMMITTEE

2.1 Purpose of Committee

The purpose of the XXX Governance Committee is to provide the NHS Board with the assurance that –

-

2.2 Composition

During the financial year ended 31 March 2019 membership of **XXX Governance Committee** comprised:

- Chairperson –

MEMBERSHIP

IN ATTENDANCE

2.3 Meetings

The Committee met on four occasions during the period from 1 April 2018 to 31 March 2019 on the undernoted dates:

-

The attendance schedule is attached at Appendix 1.
All meetings of the XX Governance Committee were quorate.

2.4 Business

The Committee considered both routine and specific work areas during the financial year 2018/2019. Areas considered included:

-

Full details of the business items considered are attached at Appendix 2.

Minutes of the meetings of the Committee have been timeously submitted to the Board for its information.

3. OUTCOMES

Through the financial year the Committee were presented with various items and these can be summarised as follows:-

Title and brief outline of each

4. CONCLUSION

STATEMENT OF ASSURANCE

As Chair of the XXX Governance Committee during financial year 2018/2019 I am satisfied that the integrated approach, the frequency of meetings, the breadth of the business undertaken, and the range of attendees at meetings of the Committee has allowed us to fulfil our remit as detailed in Standing Orders. As a result of the work undertaken during the year I can confirm that adequate and effective XXX Governance arrangements were in place across NHS XXX during the year.

I would again pay tribute to the dedication and commitment of fellow members of the Committee and to all attendees. This past year has seen many changes to the XXX Governance Committee. I would thank all those members of staff who have prepared reports and attended meetings of the Committee and XXX for their excellent support of the Committee.

Name
Chairperson
On behalf of XXX GOVERNANCE COMMITTEE

XXXXXX GOVERNANCE COMMITTEE ATTENDANCE RECORD – 2018/19

NAME	POSITION	ORGANISATION	Date	Date	Date	Date

NAME	POSITION	ORGANISATION	Date	Date	Date	Date
IN ATTENDANCE						

Key

P – Present
CC – via conference call
A – Absent – no apologies received
AA – Absent – apologies received
- Attendance not required

STAFF GOVERNANCE COMMITTEE
SCHEDULE OF BUSINESS CONSIDERED 2018 - 19

DATE OF MEETING	TITLE OF BUSINESS DISCUSSED

NHS Greater Glasgow & Clyde	
Meeting:	**Board Meeting**
Date of Meeting:	**25th June 2019**
Purpose of Paper:	**For Noting**
Classification:	**Official Sensitive/Board Official (delete as appropriate)**
Name of Reporting Committee	**i.e. Acute Services Committee**
Date of Reporting Committee	
Committee Chairperson	

Paper Title: Update on Key Items of Discussion at Governance Committee

Recommendation:

That the Board note the key items of discussion at the recent meeting of the NAME OF COMMITTEE as set out below.

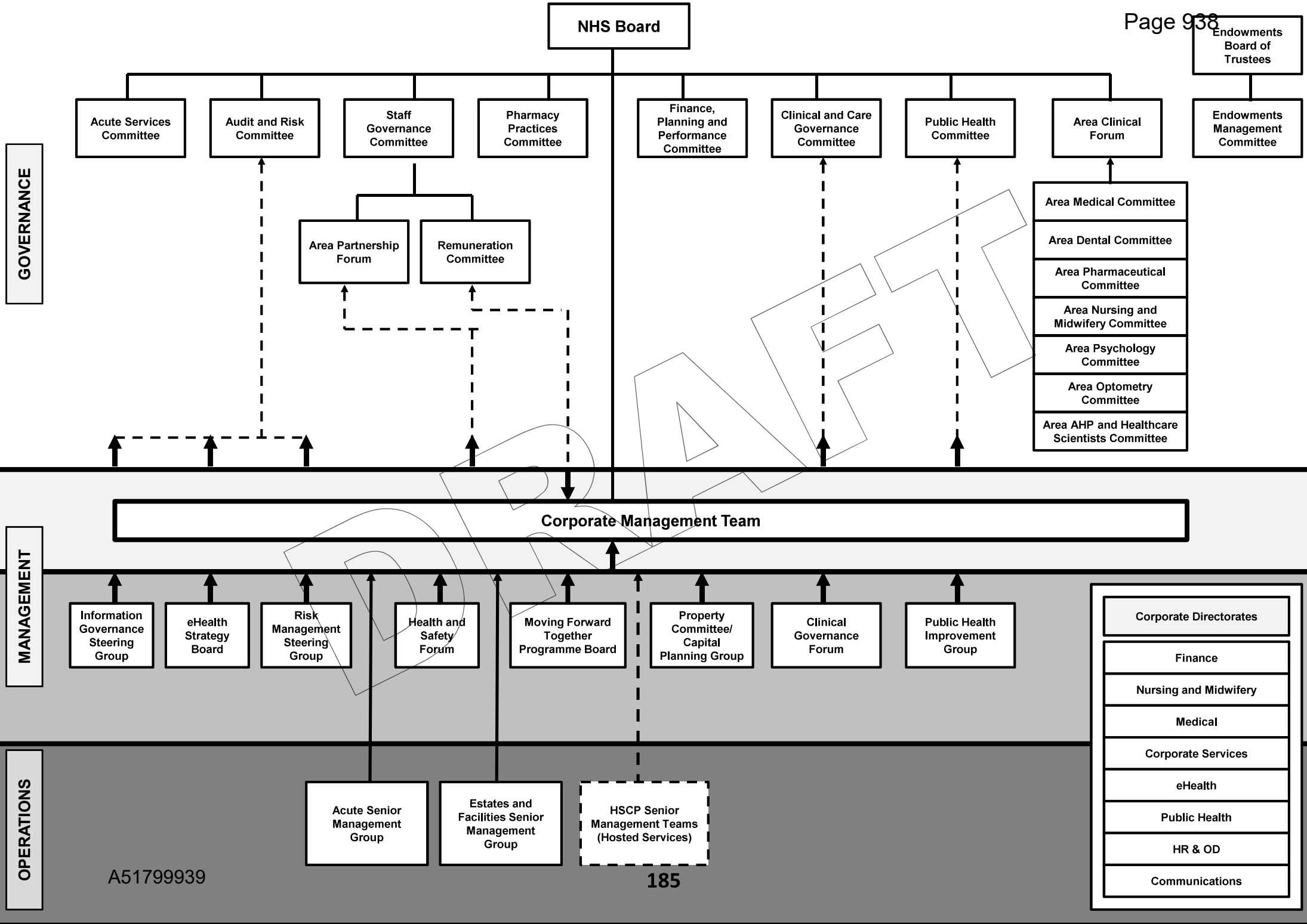
Key Items of Discussion:

1. Key item of discussion 1
2. Key item of discussion 2
3. Key item of discussion 3

…

NHS Greater Glasgow and Clyde

Draft Governance Framework
Diagram of Committees


NHS Board
Endowments Board of Trustees
GOVERNANCE
Acute Services Committee
Audit and Risk Committee
Staff Governance Committee
Pharmacy Practices Committee
Finance, Planning and Performance Committee
Clinical and Care Governance Committee
Public Health Committee
Area Clinical Forum
Endowments Management Committee
Area Partnership Forum
Remuneration Committee
Area Medical Committee
Area Dental Committee
Area Pharmaceutical Committee
Area Nursing and Midwifery Committee
Area Psychology Committee
Area Optometry Committee
Area AHP and Healthcare Scientists Committee
Corporate Management Team
MANAGEMENT
Information Governance Steering Group
eHealth Strategy Board
Risk Management Steering Group
Health and Safety Forum
Moving Forward Together Programme Board
Property Committee/ Capital Planning Group
Clinical Governance Forum
Public Health Improvement Group
Corporate Directorates
Finance
Nursing and Midwifery
Medical
Corporate Services
eHealth
Public Health
HR & OD
Communications
OPERATIONS
Acute Senior Management Group
Estates and Facilities Senior Management Group
HSCP Senior Management Teams (Hosted Services)

NHSGGC (M) 21/02
MINUTES: 10 - 25

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
NHS Greater Glasgow and Clyde Board
Held on Tuesday 23rd February 2021, at 9.30 am
via MS Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Dr Margaret McGuire
Cllr Caroline Bamforth	Ms Ketki Miles
Ms Susan Brimelow OBE	Mr Allan MacLeod
Mr Simon Carr	Cllr Jonathan McColl
Cllr Jim Clocherty	Ms Dorothy McErlean
Mr Alan Cowan	Cllr Iain Nicolson
Professor Dame Anna Dominiczak	Mr Ian Ritchie
Professor Linda de Caestecker	Mr Francis Shennan
Ms Jacqueline Forbes	Ms Paula Speirs
Mrs Jane Grant	Ms Rona Sweeney
Cllr Mhairi Hunter	Ms Flavia Tudoreanu
Mrs Margaret Kerr	Mrs Audrey Thompson
Ms Amina Khan	Mr Charles Vincent
Mr John Matthews OBE	Mr Mark White

IN ATTENDANCE

Ms Fiona Aitken	..	Royal College of Physicians of Edinburgh
Mr Callum Alexander	..	Business Manager
Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Professor Michael Deighan	..	Royal College of Physicians of Edinburgh
Mr William Edwards	..	Director of eHealth
Mr Graeme Forrester	..	Deputy Head of Board Administration
Ms Jennifer Haynes	..	Corporate Services Manager – Governance (Minute)
Ms Lorna Kelly	..	Director of Primary Care
Ms Louise Long	..	Chief Officer, Inverclyde HSCP
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susan Manion	..	Interim Director of GP Out of Hours
Mrs Geraldine Mathew	..	Secretariat Manager
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Julie Murray	..	Chief Officer, East Renfrewshire HSCP
Mr Tom Steele	..	Director of Estates and Facilities
Ms Shiona Strachan	..	Interim Chief Officer, Renfrewshire HSCP
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
10.	**WELCOME AND APOLOGIES**		
	Professor John Brown welcomed those present to the meeting, and particularly Professor Michael Deighan and Ms Fiona Aitken who were carrying out a review of Board Effectiveness. The meeting combined members joining via video conferencing, and a socially distanced gathering of some members within the Boardroom of JB Russell House. Professor Brown reminded members of the appropriate etiquette during the online discussion, and also reminded everyone that the meeting was public. Member apologies were intimated from Ms Anne Marie Monaghan. Senior Management apologies were intimated on behalf of Ms Caroline Sinclair. **NOTED**		
11.	**DECLARATION(S) OF INTEREST(S)**		
	Professor Brown invited members to declare any interests in any of the items being discussed. Professor Brown also reminded members of the requirement to keep their details on the register of interest up to date. Mr Charles Vincent noted an interest in Item 8, and confirmed that he would not participate in that discussion. Mr Francis Shennan noted that he too had previously declared an interest in Item 8. **NOTED**		
12.	**INVOKING OF STANDING ORDER 5.22**		
	Professor Brown described the proposal to invoke Standing Order 5.22 in relation to three items: QEUH legal claim update, the UK Infected Blood Inquiry and Glasgow Royal Infirmary Car Park. Professor Brown noted that the advice from the Board's legal advisors that these items could, and should, be taken in private session. **APPROVED**		
13.	**MINUTES OF PREVIOUS MEETING**		
a)	**MINUTE OF THE MEETING HELD 22nd DECEMBER 2020**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on 22 December 2020 [Paper No. NHSGGC (M) 20/07]. On the motion of Mr Alan Cowan, seconded by Ms Audrey Thompson, the minute of the meeting was approved and accepted as an accurate record. For Item 106 (Draft Stakeholder Communication and Engagement Strategy), it was noted that the action plan should be added to the Rolling Action Log.		Elaine Vanhegan

	For Item 107 (Brexit Update) an update was requested from the Executive Team. Mrs Jane Grant confirmed that there had been discussion at the last CMT meeting, and that although there were some minor issues, there were no concerns of major significance. Mrs Anne MacPherson affirmed this message, noting that although there was new customs paperwork which had caused minor delays, actions had been taken to address issues raised. **APPROVED**		
b)	**MINUTES OF THE MEETING HELD 19TH JANUARY 2021**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on 19 January 2021 [Paper No. NHSGGC (M) 21/01]. Mr Simon Carr and Ms Flavia Tudoreanu noted they had not been included in the attendance list. Professor Brown apologised for the omission, and noted this would be rectified. On the motion of Mr Allan MacLeod, seconded by Mr Ian Ritchie, the minute of the meeting was approved and accepted as an accurate record. **APPROVED**		
14.	**MATTERS ARISING**		
a)	**BOARD ROLLING ACTION LIST**		
	The Board considered the Rolling Action List of the NHSGGC Board [Paper No. 21/02] Members agreed to the closure of the outstanding actions. **NOTED**		
15.	**CHAIR'S REPORT**		
	Professor Brown made reference to the revised governance arrangements, and noted he had received no negative comments from Board members as a result of the temporary suspension of some of the Board Committees, and that the arrangement appeared to be working well. It was noted that the Audit and Risk Committee would proceed as planned on 16 March 2021. This decision had been made following discussion with the Chair of the Audit and Risk Committee and the Director of Finance, and was reflective of the end of year financial cycle, and the need to ensure smooth running of the end of year accounts. Professor Brown described that the papers for today's Board Meeting, and confirmed that the system was still under considerable stress as a result of COVID-19, so the interim governance arrangement would continue until the April 2021 Board Meeting, when a paper would be brought to decide whether to resume business as usual, or to continue with the interim arrangements for a further period. He reminded Board Members that there remained the provision for ad-hoc, single agenda item Standing Committee meetings between now and the April meeting, should the need arise.		Elaine Vanhegan

	Professor Brown highlighted he had attended a number of meetings with Ministers, including the Cabinet Secretary, over the last two months. Key points of discussion were COVID-19 and the vaccination programme, as well as urgent scheduled care, recovery and remobilisation. He noted that the purdah arrangements would begin from 25 March 2021. Professor Brown also provided an overview of a meeting with the First Minister, NHS Chairs and Chief Executives which focussed on the vaccination programme. He also described meetings with the West of Scotland Chairs and Minister for Public Health, as well a meeting with Chair of the Oversight Board, as their work was coming to a conclusion. Professor Brown described that he had been interviewing for new Board Members, and that the panel had recommended two people – one from a financial background, one from a primary care background – to the Cabinet Secretary for appointment. Professor Brown welcomed the background of both candidates, noting the attributes they would bring, and that the Cabinet Secretary had been encouraging strengthening relationship between primary and secondary care. Also since the last Board Meeting, Professor Brown had met with Ms Jenny Gilruth MSP, Minister for Europe and International Development, regarding the NHS Scotland Global Citizenship Programme. Professor Brown described that part of the discussion had been whether the approach developed by NHS Scotland could be applied to other Scottish public bodies. Professor Brown also described regular MP/MSP Briefing Sessions that were now taking place, and that those had been very well received by those MP/MSPs in attendance. Professor Brown went on to describe discussions with the Universities of Glasgow and Dundee, regarding how academia and Health Boards can work together to support leadership development going forward. **NOTED**		
16.	**CHIEF EXECUTIVE'S REPORT**		
	Mrs Grant provided an overview of key elements of focus since the last meeting. She noted that the COVID-19 position remained very challenging, both in Acute and Partnerships. Mrs Grant was working closely with Local Authority Chief Executives, and described positive dialogue. Mrs Grant was also in regular discussions with West of Scotland Health Board Chief Executives, to ensure ongoing discussion of regional issues. Mrs Grant described that she was a member of the national steering group for Test and Protect, and that the focus of many meetings was around the vaccination programme, to make sure progress was as swift as possible. Mrs Grant also made reference to meetings with the First Minister, Cabinet Secretary and the MP/MSP briefings, noting that these had been positive, as constituents had been approaching their MP/MSPs with many questions, mainly related to COVID-19 vaccination. Mrs Grant noted that there had been an unannounced HEI visit to the Vale of Leven Hospital (VOLH) since the last meeting. Whilst the formal report		

	was awaited, initial feedback had been very positive. The GP Out of Hours Service at the VOLH had returned to full hours, and there was ongoing discussions with national colleagues about consolidating the redesign of unscheduled care. Mrs Grant confirmed that there had been several meetings with the Oversight Board, to assist them in their work. Professor Brown thanked Mrs Grant for the update, and invited comments and questions with regards to both the Chair and Chief Executive's respective updates. Ms Ketki Miles conveyed that she understood the interim governance arrangement, but asked how media related issues would be managed during purdah, as well as asking for an update on the senior management capacity. Ms Miles also asked about remobilisation, and creating capacity by Summer 2021. Professor Brown made reference to the Remobilisation Plan, and Mrs Grant confirmed a first draft was due and would be complete by 26 February 2021. Thereafter, there would be ongoing dialogue for some time with the Scottish Government regarding their feedback on it, and with their agreement, the plan would come to a future Board Meeting. Mrs Grant described the close working with the Scottish Government over the Remobilisation Plan, which tended to be a work in progress for a period, and had to be signed off by the Scottish Government, so they could be assured of equity across NHS Scotland. With regards to the question about media issues during purdah, Professor Brown described that the Board had good experience of this, and Ms Sandra Bustillo confirmed that there was very clear and explicit guidance during purdah. In terms of leadership, Mrs Grant confirmed that leadership capacity was regularly reviewed, and that the resource had and would continue to be augmented. Mrs Grant noted that senior and middle graded colleagues were currently being sought for Ms Vanhegan' s team, given the demands on Corporate Services, for example, due to the Public Inquiry. In terms of the wider leadership, the vast majority of the additional posts committed to had now been filled. Professor Brown added that the Remuneration Committee was furnished with reports on both proposed and complete changes to senior leadership posts. Ms Susan Brimelow stated that she was interested in hearing about the unannounced visit at VOLH, but felt it was also important to mention the positive inspection at Leverndale Hospital. Mrs Grant apologised this was not mentioned, as the team there should be commended on such an excellent report. Professor Brown acknowledged that there had been a lot of positive improvement in service delivery and patient care across the NHSGGC, despite the significant second wave of COVID-19 in recent months. **NOTED**		

17.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update [Paper No. 21/03] presented by Mrs Grant. The paper provided an overview of progress in respect of the various issues regarding the QEUH and RHC. Mrs Grant provided a summary, confirming that the Interim Oversight Report had been published before Christmas 2020. Clarity had been required over some of the recommendations, and there has been ongoing dialogue with the Scottish Government in that regard, helping to reach a clearer position. In the meantime, focus had been on making improvements with an internal Executive Oversight Group, which meets on a weekly basis, overseeing progress. Mrs Grant further expanded by noting that one of the areas of focus was a further look at communications with families, and also engagement with staff. The report also contained a number of national recommendations, which the Health Board was participating with, in collaboration with the Scottish Government. Mrs Grant also gave an update on the refurbishment of Wards 2A and B of the RHC. The capital scheme had been going well, but had temporarily been delayed due to a COVID-19 outbreak in the construction workforce. In terms of the QEUH Independent Review published in June 2020, Mrs Grant confirmed that there was an action plan in place, and that work continued on the recommendations. Mrs Grant noted that the paper outlined the timelines involved with the Scottish Hospitals Public Inquiry. NHSGGC had received a substantial information request, and there was dialogue on going with the CLO and the Inquiry Team to manage the request. Mrs Grant made reference to the legal claim in respect of the QEUH and RHC, and confirmed that this would be discussed in more detail during the private session. Mrs Grant also confirmed that the Case Note Review report was expected imminently. Professor Brown thanked Mrs Grant for the overview given, and invited comments and questions from members. In response to a question about the HSE investigation, and whether the timescales for appeal posed a problem or increased risk, Mrs Grant confirmed that there had been close working with the HSE. Mrs MacPherson elaborated by confirming that there had been joint discussions, timescales were agreed collectively, and delays had been due to COVID-19. Senior Counsel were involved, and there was confidence in the approach being taken. Regular reports were provided to the Corporate Management Team and Health and Safety Forum. In response to a question regarding staffing resource to deal with the reviews and the Public Inquiry, and the impact on day to day leadership, Mrs Grant confirmed that capacity was being actively reviewed by the senior team. Significant investment and additional posts had been put into the		

	Communications Team, and as highlighted previously additional staff were being put into Corporate Services and the Programme Management Office. In discussing the Interim Oversight Board Report regarding improvement and compliance with regards to all staff and disciplines, Professor Brown noted that the Oversight Board Work was incomplete at the moment, and there were ongoing discussions with Professor Fiona McQueen, Chief Nursing Officer for Scotland and Chair of the Oversight Board. In relation to communication around the Public Inquiry and the HSE, given the sensitive subject matter, Ms Bustillo highlighted that there were meetings on a weekly basis to look at all matters regarding the QEUH and RHC, which included discussions about communications and media responses, so planning and preparation was well underway. Professor Brown added that there was close partnership working between NHSGGC and Scottish Government around communication. The additional steps in the escalation process did, unfortunately, mean that sometimes it appeared as if NHSGGC had made no comment, when the intention had been to respond, but the deadline was not met while NHSGGC waited for clearance from the Scottish Government of our draft response. Mrs Grant provided an update on the CaseNote Review and confirmed that the outcome of the Case Note Review was expected at the same time as the finalised Oversight Board Report. In terms of timescale, some of the professionals involved with the Case Note Review had been diverted to the COVID-19 effort. Understandably, this had caused some delay in finalising the report. Reference was made to paragraph 44 of the Interim Report, and it was confirmed that those issues had been considered through the Board Clinical Governance Committee. It was reiterated that there would be a final report, with more detail, and we required to await that publication. Professor Brown also confirmed that he had written to Professor McQueen requesting that the final report was written in a language and tone which was easy to understand by wide range of stakeholders. In discussion, it was noted that the Public Inquiry Team, had requested information on governance and project management as far back as 2002, with a question posed as to whether the Board would be in a position to respond. Mrs Grant acknowledged that this would potentially be a challenge and that requests were wide ranging, however significant work was underway to ensure information was made available. **NOTED**		
18.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 21/04] presented by Professor Linda de Caestecker. The paper provided an overview of the overall position in respect of the NHSGGC response. Professor de Caestecker noted that although rates of infection had gone down substantially since the peak in mid-January 2021, the decline had started to slow, and it had been fairly static over last few days. Professor de Caestecker described that different Local Authority areas were seeing different rates of infection, and that most clusters were in workplace		

	environments. 70 workforce clusters were being investigated at the moment, and Professor, de Caestecker said this was likely due to lockdown fatigue. Professor de Caestecker confirmed that there were 793 COVID-19 positive inpatients in hospital at that moment, 33 of whom were in ICU. Professor de Caestecker noted the number of infected patients was also coming down in community assessment centres, but similarly, was beginning to plateau. Professor de Caestecker summarised by noting that whilst there was an overall improved picture, the situation remained very challenging and there was no room for complacency. There were currently 10 active outbreaks in Care Homes, but the hope was to reopen for indoor visiting again soon. A substantial expansion of testing had been seen in recent weeks, including for teachers and senior secondary school pupils, as well as looking at prison staff and new admissions to prisons. A lot of work was also being undertaken with local authority colleagues regarding community testing, and there would be 7 asymptomatic testing sites across Glasgow from the beginning of March 2021. Professor de Caestecker confirmed that there was now a focus on how mass community testing was adapted, concentrating on more deprived areas and target groups that had not been accessing testing to the same degree. A key part of that was targeted isolation support (for people concerned of financial or other implications of COVID-19). Professor de Caestecker also mentioned the managed isolation of travellers coming from overseas, and that there were 2 hotels involved with that. Professor de Caestecker spoke about the vaccination programme, noting that in NHSGGC, 290,000 people had received their first dose of vaccinations. Second dose vaccinations had begun for Health and Social Care staff. Professor de Caestecker confirmed the vaccination programme was now on cohort 6 (age 60-64 at risk), which would continue until the end of March 2021. Professor de Caestecker noted that there had been some vaccination supply delays, meaning reduced schedules, which was a national issue. Professor Brown thanked Professor de Caestecker and her team for how effectively and professionally they had responded to the pandemic, and invited members' comments or questions. In response to a question about the scale of delay with supply and resistance to getting vaccinations, Professor de Caestecker explained that the vaccine supply position changed daily. She explained that NHSGGC had been asked to accelerate delivery, which was done for the first 5 cohorts, and now supply had reduced. There was still confidence that cohort 6 would be completed by the end of March 2021. This changing situation had meant that schedules had been adjusted. Professor de Caestecker noted, that although it was frustrating for the public, delays were unfortunately unavoidable. With regards to vaccine refusal, there had been some misplaced concern about whether the vaccine impacted fertility, but overall the update rate was high, at 93%. This rate was increased further when vaccination teams were on, for example, Care Home sites, so they could talk to those receiving the vaccine and offer reassurance. Professor de Caestecker confirmed there had also been webinars and radio messages to reassure that the vaccine is safe.		

	In response to a question on continuing symptoms, Professor de Caestecker explained that there was learning all the time about long COVID-19, and guidelines had just been published which recommended a primary care approach to symptomatic support, acknowledging, that for some patients who had been very sick, recovery was unfortunately likely to take some time. Mr Mark White commented that there was a current bid about to be submitted via the Endowment Committee to seek additional members of staff for the Occupational Health Department, specifically to support the impact of long COVID-19. It was hoped that the bid would be successful, to augment how staff are supported. Mrs MacPherson also advised of the positive work of Physiotherapy and Occupational Therapy Teams regarding guidance and support to rehabilitate patients. Success with this year's flu vaccination programme was noted, along with the low levels of COVID vaccination wastage which was welcomed by the Board. In response to a question regarding recommencing elective work whilst staff were rolling out vaccinations and undertaking other COVID related activity, Mrs Grant confirmed that Mr Jonathan Best and his team were working hard looking at Priority 2 elective patients, and the displacement of staff would not impact on that activity. In discussion regarding the significant improvement in the 4-hour Emergency Department (ED) target, Mr Best described that following the first wave, there was a decline in numbers attending ED, however, those that were attending ED now, were more unwell. The new Navigation Flow Hubs had thus far appeared successful, with an average of 100 calls a day, and a redirection rate of 30% to self-care, primary care or minor injuries. Mr Best noted that whilst we remained in the midst of the pandemic, the national 'hard launch' of the redesign of unscheduled care was on hold. In response to a question about vaccination rates for people with learning disabilities, Professor de Caestecker noted that there was work underway nationally to understand the take up rates amongst different groups, but this was unknown at the moment. There appeared to be general enthusiasm across all groups to receive the vaccine. Ms Julie Murray elaborated, stating that the community learning disability teams were supporting their clients to attend for vaccinations and were undertaking the vaccination for some clients, depending on their needs. Ms Bustillo confirmed that there was an FAQ section on the NHSGGC website, which was posted last week, and was based on the key themes from social medial. In addition, a number of individual queries had been dealt with off line. Mrs Grant reassured Board members that NHSGGC was responding to a significant number of queries from MP/MSPs on behalf of constituents, and the feedback on how those had been handled was very positive. Mrs MacPherson commented on uptake rates amongst staff, noting the focus to support BAME workers, pregnant workers, and staff with allergies and reactions. These groups of staff in particular had been supported, to allay any anxieties about the vaccination. Vaccinations were voluntary, and		

	whilst staff were encouraged to have it, they were still supported if they chose not to. In respect of lessons to be learned to prevent outbreaks, Professor de Caestecker confirmed that all outbreaks were investigated. She noted that an issue in workplaces was mainly related staff behaviour when off duty, as lockdown FACTS were not always being followed, and this was a very common theme amongst all outbreaks. In response to a question regarding the booking system, Professor de Caestecker confirmed that when vaccine supply reduced at short notice, on one occasion we had had to cancel clinics and re-book people to other clinics. There were also a number of people who needed to re-book due to weather conditions. The team managed to contact most people but a few people were impossible to contact. Mr William Edwards confirmed that there was both national and local teams, who do a number of collaborative checks and balances. The local team can arrange short notice changes, and that is done at individual patient level, and whilst there have been a small number of issues, overall the system was working well. Professor de Caestecker confirmed that the effectiveness of vaccines was reassuring, and we will hopefully start to see the impact of that on acute hospital admissions in the near future. Second doses for Health and Social care staff have begun, and that will continue to run through March 2021. Professor Brown expressed his thanks to everyone at every level and location of across NHSGC for their hard work and commitment. **NOTED**		
19.	**NHSGGC PERFORMANCE UPDATE**		
	The Board considered the paper 'NHSGGC Performance Update' [Paper No. 21/05] presented by Mr White. Mr White gave a brief overview of the paper, noting that the Board remained committed to achieving its commitments, and that of the 14 indicators, 8 were green, 2 were amber and 4 were red. In the context of the pandemic, this was considered to be a good achievement. Professor Brown agreed that there had been an excellent level of performance during a very challenging time, and it was encouraging to see improvement in some areas. He invited comments and questions from members. On considering the sustainability of the reduction in ED attendances, and performance against the 4 hour target Mr Best highlighted that during the first wave of the pandemic, there was a change to the number of people walking into ED, marking a change in societal behaviour. Mr Best confirmed that this pattern was continuing during the second wave, and it was important to move away from a culture of using ED inappropriately. Mr Best made reference to encouraging people to phone 111 before attending ED. In terms of performance, Mr Best confirmed this was a delicate balance. A number of wards were closed due to COVID-19, and the pandemic still presented acute care with many challenges. However, the reduced demand on ED and improved performance was encouraging.		

	In response to discussion on target forecasts, Professor Brown responded that Ms Vanhegan was currently leading on work related to the Assurance Framework, and that the next step was to look at reports, monitoring, risks, and results. Professor Brown noted he expected a new package in place by the June 2021 Board. In respect of staff sickness absence Mrs MacPherson noted there were a range of codes for COVID-19 absence, with over 600 staff shielding at the moment. At its peak last year, this figure was over 1000. Mrs MacPherson explained that 15,000 staff now have the ability to work from home. She further explained there was more rigour around absence processes and systems, with a dedicated COVID-19 support team. There was also little flu related illness, which had helped contribute to an improved figure. Professor Brown noted that it was important to acknowledge the commitment of staff, which should not be underestimated. In response to a question regarding delayed discharges, particularly in respect of adults with incapacity and in relation to pressure on the court system, Ms Susanne Millar stated that this issue had been raised on a number of occasions with the Scottish Government, and with Local Authority Chief Executives. Regrettably, it was not possible to influence the speed at which the court system moved. Dr Margaret McGuire agreed with this, further noting that there was no other way, as court processes required to be followed to ensure appropriate protections for these patients. In relation to CAMHS performance, Mrs Grant noted there was a full recovery plan in place, however during the pandemic the whole dynamic of the waiting list had changed with lists now having to be prioritised accordingly, and therefore, were not comparable to previous years. Ms Manion also noted that there was an improvement plan across HSCPs in conjunction with Specialist Children's' Services to move much closer to waiting times targets. As well as clinical urgency, those who had been waiting longest were also a priority, in order to ensure the right and fair pathway. Professor Brown thanked colleagues for the performance update and Board members questions. **NOTED**		
20.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	Professor Brown introduced Professor Angela Wallace to talk to her paper 'Health Care Associated Infection Report [Paper No, 21/06]. Professor Wallace noted that she would focus on the main points of the paper, hoping that the information helped demonstrate the hard work being undertaken by the team. Professor Wallace reported a stable performance which was within statistical control limits. The control line (mean) had been reduced over time, which indicated improvements over time in relation to Staphylococcus aureus bacteraemia (SAB), Clostridioides difficile infection (CDI), and Escherichia coli bacteraemia (ECB).		

	Professor Wallace made reference to hospital acquired infection associated with the use of intravenous devices, hand hygiene and national cleaning and estates performance. Professor Wallace noted that almost a third of patients have IV access devices, so the number of infections that were related to this were proportionately small, however, work continued to drive the rate down even further. Professor Wallace acknowledged that the work with Mr Tom Steele's team in Estates and Facilities had been fundamental, and this was reflected in the data presented. Professor Wallace noted the unannounced inspection in VOLH and reiterated the earlier comments that initial feedback was positive. Professor Wallace noted that the team continued to work flexibly during the COVID-19 pandemic, to ensure infection control advice was readily available to clinical teams. Recommendations from aforementioned reports were being put into action by the team. Professor Brown thanked Professor Wallace, and members were invited to make comments or ask questions. In response to a question regarding SABS, Professor Wallace confirmed that despite screening and monitoring, specific reasons for the slightly higher SAB and ECB rates had not been identified. However, in terms of ECB, this was a target that was found challenging nationally as our ability to affect it through working practices was limited to urinary catheter care. In terms of note made on care plans and audits, this was confirmed as being in relation to completing paperwork rather than care not being delivered, and Professor Wallace confirmed that Dr McGuire's team were currently looking at streamlining documentation. In respect of the Langlands Unit, where compliance was below other areas, Professor Wallace noted that there were external cleaning contractors (Serco) in the Langlands Unit, and she had spent time there, in conjunction with Mr Best, to support external colleagues being part of daily huddles, to improve operational responsiveness. Mr Steele confirmed that in terms of dialogue with Serco, they had undergone challenges in terms of standards and capacity issues, but they had sought help from NHSGGC. The standards now maintained in Langlands were consistent with national standards. Professor Brown thanked Professor Wallace, and asked whether she felt NHSGGC's rates were within acceptable limits, providing an environment for safe patient care. Professor Wallace replied in the affirmative, and commented on NHSGGC's Professional and proactive approach. **NOTED**		
21.	**NHSGGC FINANCE UPDATE**		
	The Board considered the paper 'NHSGGC Finance Update' [Paper No. 21/07] presented by Mr White. Mr White began by giving an overview of projected 2020/21 out turn, stating that unachieved savings was £22m due to the COVID-19 effort. More recently, the Scottish Government required an updated Quarter 3 forecast.		

	A total forecast for COVID-19 was submitted of £176m, which included the vaccination programme. Mr White confirmed that NHSGGC had been allocated £169m of funding for COVID-19, with more expected at the end of February 2021. This meant that COVID-19 spend would be covered. Mr White confirmed that a breakeven position was predicted for 2020/21. Mrs Kerr noted that achieving that position would have required a lot of work, and was keen that this was recognised. Professor Brown asked about the East Dunbartonshire HSCP overspend, but Mr White reassured that they too were expected to breakeven by the end of the financial year. In response to a question regarding any underspend as a result of centrally funded COVID-19 monies, and if it would be possible to carry that into 2021/22, Mr White confirmed that although the Scottish Government would fund COVID-19 spend, there would be no excess to carry over. Professor Brown asked at what point the Board needed to approve revenue funding that goes into capital, but Mr White confirmed it was still too early. Mr White next provided an overview of the initial financial plan for 2021/22, noting that the Scottish Government announced their budget in January 2021, but that Westminster budget would not be announced until 3 March 2021. The Scottish Government budget noted an uplift of 1.5% on the baseline level. The Scottish Government had also announced the budget for specific COVID-19 and remobilisation costs. Mr White also described specific investment in primary care, for GP contracts and reform. Tackling waiting times was also a key priority, as was monies for alcohol and substance misuse, mental health and CAMHS. For NHSGGC, the biggest areas of pressure remained pay increases and prescribing. Mr White confirmed that he and his team were still finalising the list of investments and spend, that would be linked with the remobilisation plan. Mr White confirmed there was 5.8% pressure, which was slightly better than last year, and that he and his teams were working on programmes to help address that, with the key objective to reduce the underlying recurring deficit. Professor Brown thanked Mr White for the update, and for the work he and his team had undertaken. In response to a question regarding the Financial Improvement Plan, Mr White noted that circa £12m had been taken out of recurring savings, and the remaining gap was non-recurring. Mr White added that a challenge was the change in business, and the difficulty in ascertaining what would be recurring and non-recurring going forward, in terms of what services needed to remain, and what would revert to as it was pre COVID-19. Mr White confirmed that a presentation would be delivered at the next Finance, Planning and Performance (FP&P) Committee. It was recognised that usually at this time of year, there would be a more detailed analysis of the budget undertaken at the FP&P Committee, and concern was expressed that due to revised governance arrangements there		

	would not be an FP&P committee for some time. Professor Brown noted that this was a timing issue, and also made reference to the capacity of the Executive Team during such a challenging time. Professor Brown confirmed there would be a further update from Mr White, when the full governance arrangements were re-established, and there would therefore be a FP&P committee meeting before the June 2021 Board Meeting. In the meantime, Mr White would discuss with Mr MacLeod the possibility of utilising the Audit & Risk Committee to provide a further opportunity for scrutiny of the year-end position and next year's budget projection by Board Members, before the April Board meeting. Clarity was sought regarding recurring costs, given the uncertainty about what would continue, what would revert back to 'business as usual', and how that would be agreed with the Scottish Government. Mr White agreed there was uncertainty at the moment. For example, the elective programme was underspent, due to the temporary reduction in service, and that a full elective programme would need to come back gradually. However, in other areas, there was overspend. For that reason, it was challenging to give a definitive picture of future spend. Professor Brown thanked Mr White, noting that 2021/22 would look different financially, as this would reflect the Scottish Government's expectation of the remobilisation plan. **NOTED**		Mr White
22.	**NHSGGC REMOBILISATION PLAN UPDATE**		
	Professor Brown invited Dr Jennifer Armstrong to present her paper 'NHSGGC Remobilisation Plan Update' [Paper No. 21/08] Dr Armstrong noted that Remobilisation Plan 3 (RMP3), as the name suggested, was the third iteration of the plan. It built on previous plans, outlined a core set of priorities, and was developed in collaboration with a range of staff, including clinicians and members of tactical groups. The Scottish Government had sent a commissioning letter on 14 December 2020, with the key things they required Boards to focus on. RMP3 therefore ensured these areas of focus had been covered. Dr Armstrong talked through her presentation, noting key priorities, which were at national, regional and local levels. She noted the achievements of 2020/21 with a clear project plan, and confirmed most of the targets in RMP1 and RMP2 had been met. In terms of the governance, Dr Armstrong confirmed that a range of managers and clinicians sat on tactical groups, and significant strategic issues went through the appropriate Board governance route. Dr Armstrong noted that there was a balance between ensuring non COVID-19 patients were treated in clinical priority, with ensuring significant capacity for COVID-19 patients was retained. In the 12 months ahead, the ambition was to consolidate the positive changes that had been made in response to COVID-19, as well as to remobilise.		

	The plan was to finalise RMP3 this week, and submit it to the Scottish Government for review. The final plan would be complete in April / May 2021. Professor Brown thanked Dr Armstrong, noting that there was a lot of information, and members may find it helpful for the presentation to be circulated. He confirmed that at that stage, the Board was not yet being asked to approve anything. He noted the ambition of the plan in trying to achieve a lot of things, and expressed his contentment at the strategic fit, Professor Brown stated that he found it assuring that patient engagement would continue as a priority. Ms Dorothy McErlean noted she had met with Dr Armstrong, and that RMP3 had been through staff side engagement, and had been reasonably well received. There had been recognition of the challenge staff had been through, and what had been put in place to support them. Ms Audrey Thompson noted that RMP3 had been presented to the Area Clinical Forum, where there was strong support from clinicians, whilst recognising the challenges. Mrs MacPherson reported similar views from the Medical and Dental Staff Forum. Professor Brown asked about external communications for RMP3, and Mrs Grant noted that it was important that there was Scottish Government approval on the plan first. In response to a question on the SACT plan, Dr Armstrong noted that this aspect needed significant work to ensure a project plan was developed, and to agree capital and revenue funding. This would be considered alongside the other Board priorities for capital. The purpose of this aspect of the plan was about future proofing the Beaton West of Scotland Cancer Centre, and moving chemotherapy treatment to local areas. Professor Brown noted in response to whether the paper was for approval or noting, that the plan would be agreed by the Scottish Government in the first instance, before a final version coming back to the Board for approval. In response to a question on the appointment of an LGBT diversity champion, Mrs MacPherson noted that consideration was being given to how the Board supports all the communities with protected characteristics and committed to taking this forward. In response to a question on the ambition of the plan and the achievability of some of the targets, Mrs Grant noted there needed to be a balance between ambition, and the needs of population. For example, the 80% target for outpatients was likely achievable as current aims were being exceeded, however, elective work would be more challenging, which is why the aim is for 60% of what was previously achieved, minus our waiting list activity by Quarter 4 of 2021/22, which is realistic. It was highlighted that the Scottish Government were keen that the plan was realistic and not overly ambitious. **NOTED**		

23.	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**ACUTE SERVICES COMMITTEE**		
	The Board were content to note the minutes of the Acute Services Committee meeting held on 17 November 2020 [Paper No. ASC(M) 20/04]. **NOTED**		
b)	**CLINICAL AND CARE GOVERNANCE COMMITTEE**		
	The Board were content to note the minutes of the Clinical Care and Governance Committee meeting held on 1 December 2020 [Paper No. CCG(M) 20/03]. **NOTED**		
d)	**FINANCE, PLANNING AND PERFORMANCE COMMITTEE**		
	The Board were content to note the minutes of the Committee meeting held on 8 December 2020 [Paper No. FPPC(M) 20/04]. In response to a question about the £500 COVID-19 payment awarded to all NHS staff from the Scottish Government, Mr White confirmed it would be paid with February salaries. **NOTED**		
e)	**STAFF GOVERNANCE COMMITTEE**		
	The Board were content to note the minutes of the Committee meeting held on 3 November 2020 [Paper No. SGC(M) 20/03]. **NOTED**		
f)	**AUDIT AND RISK COMMITTEE**		
	The Board were content to note the minutes of the Committee meetings held on 15 December 2020 [Paper No. ARC(M) 20/04]. **NOTED**		
g)	**PUBLIC HEALTH COMMITTEE**		
	The Board were content to note the minutes of the Committee meetings held on 21 October 2020 and 27 November 2020 [Paper Nos. ARC(M) 20/02 and 20/03]. **NOTED**		

c)	**AREA CLINICAL FORUM**		
	The Board were content to note the minutes of the Area Clinical Forum meeting held on 10 December 2020 [Paper No. ACF(M) 20/04]. **NOTED**		
24.	**AOCB**		
	None.		
25.	**DATE OF NEXT MEETING**		
	Tuesday 27 April 2021 at 09:30am, MS Teams		

NHS Greater Glasgow & Clyde	**Paper No. 21/03**
Meeting:	**Board Meeting**
Date of Meeting:	**23rd February 2021**
Purpose of Paper:	**For Noting**
Classification:	**Board Official**
Sponsoring Director:	**Mrs Jane Grant, Chief Executive**

Paper Title

Queen Elizabeth University Hospital and Royal Hospital for Children Update

Recommendation
The Board is asked to:

- Note the update on the related work streams in respect of the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC).
- Note the Interim Oversight Board Report published in December 2020.

Purpose of Paper
To ensure the NHS Board is kept abreast of the varying issues relating to the QEUH and the RHC.

Key Issues to be considered

- The current position in respect of the escalation to Level 4 of the NHS Scotland Performance Management Framework and the Interim Oversight Board Report – which is attached at Appendix 1.
- The position regarding the recommendations of the Independent QEUH Report.
- The Scottish Hospitals Public Inquiry
- The position in relation to the pursuit of legal action for loss and damages in relation to the QEUH and RHC.
- The work the Board is progressing regarding the Health and Safety Executive investigation.

Any Patient Safety/Patient Experience Issues
Core to the work underway.

Any Financial Implications from this Paper
No defined costs at this stage however varying elements will be of significance over time.

Any Staffing Implications from this Paper
Nil specific

Any Equality Implications from this Paper
None

Any Health Inequalities Implications from this Paper
None

Has a Risk Assessment been carried out for this issue? If yes, please detail the outcome.
Not applicable

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

Author: Elaine Vanhegan
Tel No: [redacted]
Date: 14th February 2021

Queen Elizabeth University Hospital and Royal Hospital for Children Update – February 2021

1.0 QEUH/RHC and Performance Escalation

1.1 NHS GGC remains on Level 4 of the NHS Scotland Performance Management Framework in respect of what was described as on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) and the associated communication and public engagement issues.

1.2 As Board members are aware, as part of that process, an Oversight Board was established, chaired by Professor Fiona McQueen, with three sub groups reporting to the Oversight Board namely; Infection Prevention and Control Governance, Communication and Engagement and a Technical group.

1.3 NHS GGC has worked closely with the Scottish Government team throughout, providing significant amounts of evidence over the months to the sub groups, reviewing and commenting on draft reports.

1.4 On 8 December the Finance Planning and Performance Committee received a presentation outlining the findings of the draft Interim Oversight Board Report. Feedback on factual accuracy and comment on conclusions was provided to the Scottish Government in December 2020, with the Final Interim Oversight Board Report published on 21 December 2020. The Interim Report focuses on Infection Prevention and Control: Processes, Systems and Approach to Improvement and Communication and Engagement. Updates are also provided on the other strands of work. The final report will consider IPC governance, structure, responsiveness and leadership, the timing of which yet to be confirmed.

1.5 Since receipt of the final version of the Interim Oversight Board Report, an Action Plan has been developed to ensure progress against each of the recommendations. Dialogue continues with the Scottish Government to confirm what is exactly expected in respect of some of the recommendations, particularly around communication and engagement. This is being overseen by the internal Executive Oversight Group, chaired by the Chief Executive. The Finance Planning and Performance Committee will receive a further update in due course.

1.6 We continue to support the work of the casenote review which is considering all haemato-oncology paediatric patients from 2015 to 2019 who had a gram-negative bacterium identified in laboratory tests. This is being undertaken by an expert panel who are providing oversight and analysis. This work is nearing completion with the draft report expected for review and fact checking by the last week in February. Final reporting timescales are yet to be confirmed, however are likely to be aligned to the Oversight Board Final Report publication.

1.7 Work continues on Wards 2A and 2B of the RHC, which were closed in September 2018. Timescales were updated when work began on the wards and the practicalities of addressing the range of works required were more fully understood. Acknowledging the further impact of COVID-19 with cessation of activity for some weeks, the programme plan required to be updated to recognise the various mitigation measures which needed to be in place to ensure safe working, adherence to social distancing, PPE and the enforcement of these measures. The current timescale for completion is May 2021, but this is dependent on no further disruption due to the COVID situation.

1.8 Further work continues internally to address the issues associated with the Performance Escalation. An internal Oversight Board continues to meet regularly to overview progress with GP OOHs, Unscheduled Care and Scheduled Care.

2.0 Independent Review – Update

2.1 Work continues to review the actions arising from the report of the independent review of infection control concerns at the Queen Elizabeth University Hospital and the Royal Hospital for Children by Dr Andrew Fraser and Dr Brian Montgomery.

2.2 This is being progressed in accordance with the action planning methodology recommended by the Scottish Government. Progress is being monitored by QEUH Gold Command with input from appropriate Directors. All recommendations and actions relevant to NHSGGC are either complete or are fully in place with on-going monitoring.

2.3 Gold Command will receive a further update on the Action Plan in April 2021. The GGC Action Plan will also be further developed in future to incorporate the developments and outcomes of the Report recommendations being progressed by National Agencies and link, where appropriate, to Oversight Board recommendations. The Finance Planning and Performance Committee will also receive an update in respect of these recommendations.

3.0 Scottish Hospitals Public Inquiry

3.1 The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. This was a 'soft launch' with time taken to build an inquiry team and become established. On 19 January 2021 Lord Brodie announced timescales for 2021 and on the 1 February issued core participants with formal evidence requests. The content of the request is significant and is focussed on the below priorities.

- Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care
- Governance and Project Management - as far back as 2002
- Effects of the issues identified on patients and their families

3.2 The timescales announced on the 19 January noted that an initial meeting is scheduled for Thursday 18 March which is intended to be an initial gathering of legal representatives of core participants at which Lord Brodie will explain the progress of the Inquiry and the likely programme going forward.

3.2.1 The first formal hearing of the Inquiry will take place on Tuesday 22 June. This will be a procedural hearing to confirm arrangements for the first substantive hearings in September.

3.2.2 The first substantive hearings of the Inquiry will commence on Monday 20 September and will last for three weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those called upon to give evidence in person at those hearings.

3.2.3 It is likely that the next set of hearings will be scheduled for late first quarter/ early second quarter of 2022, with a procedural hearing ahead of those either end 2021/ early 2022. Further details of what will be covered and the programme for the hearing will be published in due course.

3.3 We continue to work with the dedicated team from the Central Legal Office on all issues connected to the QEUH/RHC. Supported by the CLO, NHS GGC has instructed both Senior Counsel and 2 Junior Counsel to act on the Board's behalf throughout the Inquiry.

3.4 The Programme Management Office (PMO) continues to manage the day to day requirements of the Public Inquiry in terms of administration and document flow. As a formal process is established by the Inquiry Team, the resources required are likely to increase to ensure we respond in a timely manner. The Executive Oversight Group, established, in November 2020, continues to ensure effective and transparent decision making across the process at this stage. It is important to note that some of the issues under consideration in respect of the Inquiry are directly related to those detailed in the legal claim updated below, and hence oversight of both elements is critical moving forward.

4.0 Legal Proceedings

4.1 Further to the approval of the Board in January 2019 to raise Court Proceedings against the parties responsible for delivering the QEUH/RHC construction project, the Board engaged MacRoberts LLP to act on its behalf. Court summons were served on the main contractor for the hospital project, Multiplex, and the Health Board's advisors, Currie & Brown UK Limited and Capita Property and Infrastructure Limited.

4.2 Throughout 2020, the Board continued to engage with the appointed legal team within MacRoberts. The process of seeking expert opinion against the 11 Heads of Claim was undertaken which included site visits and preliminary reports from the independent experts to assist on the question of liability.

4.3. In private session on January 2021, the Board considered the position in respect of the claim and the Board approved that NHS GGC instruct MacRoberts LLP to lodge the action for calling. This was completed on Wednesday 25th January.

4.4 Further legally privileged information will be considered in the private session of the Board on the 23rd February.

5.0 HSE Investigation

5.1 Board members will be aware that on the 24 December 2019, the Health and Safety Executive (HSE) served on NHS GGC an Improvement Notice in relation to the ventilation system for Ward 4C. Legal advice was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

5.2 After an initial hearing in the Employment Tribunal relating to the Board's appeal against the HSE Improvement Notice, it was agreed that the legal representatives of the HSE and Board would meet. Due to COVID-19 there was a suspension of activity. A preliminary hearing was held on 3 Sep 2020 with a further preliminary hearing on the 23 Nov 2020. The Court has provided a timeline for the appeal to proceed, with a hearing scheduled for around October 2021.

6.0 Summary

6.1 The many issues described in this paper represent a significant amount of work over the coming months, and indeed years in respect of the Public Inquiry. The resource requirements of the senior leadership team and supporting elements, such as the PMO, are currently being reviewed with a view to increasing the level of resource during February and March 2021.

6.2 The senior leadership team are committed to support the programmes of work described, ensuring swift action and implementation of recommendations with robust action plans. A process is being established to ensure a monitoring framework is created to track progress and ensure any required improvements are realised.

INTERIM REPORT

The Queen Elizabeth University Hospital/ NHS Greater Glasgow and Clyde Oversight Board

Findings

Progress

November 2020

Contents

Annexes

Annex A: Terms of Reference for the Oversight Board and its Subgroups

Annex B: The Peer Review Terms of Reference

Annex C: Stages of Escalation in the NHS Scotland Board Performance Escalation Framework

Annex D: Key Success Indicators of the Oversight Board

Summary: Interim Report Recommendations

This Interim Report sets out the initial findings and recommendations developed to date through the NHS Greater Glasgow and Clyde (GGC) Oversight Board's programme of work in response to the infection issues affecting the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children between 2015 and 2019. It summarises the work on investigation, dialogue and improvement from the Oversight Board's establishment in December 2019 to October 2020, and looks ahead to its remaining work and the Final Report, expected in early 2021. It captures progress and early conclusions.

The Oversight Board was put in place by the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland in November 2019. This was done to address critical issues relating to the operation of infection prevention and control, clinical governance, and communication and engagement with respect to the Queen Elizabeth University Hospital and the handling of infection incidents affecting children, young people and their families within the paediatric haemato-oncology service. The Oversight Board was a direct consequence of the escalation of the Health Board to Stage 4 of NHS Scotland's national performance framework.

The Oversight Board consists of a group of experts and key representatives drawn from other Health Boards, the Scottish Government and the affected families themselves. Chaired by Scotland's Chief Nursing Officer, Professor Fiona McQueen, the work of the Board was carried out principally through three Subgroups: Infection Prevention and Control and Governance; Technical Issues; and Communication and Engagement. Overall, the Oversight Board has been focused on assurance of current systems and reviewing the historical issues that gave rise to escalation.

In addition, an independent Case Note Review has been established to examine the individual incidents of infection among the children and young people. This report is being overseen by an Expert Panel that will be reporting in early 2021. Its findings and recommendations will inform the Oversight Board's Final Report.

This is an Interim Report; it does not provide the final summation of the Oversight Board's work, as some key activity – particularly the Case Note Review – is continuing. Consequently, this report sets out the Oversight Board's views on several (but not all) of the issues that led to escalation, and the work that remains to be done to provide assurance to Ministers and to the affected families, children and young people. It has also drawn out the wider lessons for national improvement.

The Interim Report recommendations are summarised below under the relevant key sets of escalation issues.

Infection Prevention and Control: Processes, Systems and Approach to Improvement

The Interim Report covers the following selected areas of Infection Prevention and Control (IPC):

- the degree to which specific IPC processes in the QEUH have been aligned with national standards and good practice; and
- the extent to which the IPC Team has demonstrated a sustained commitment to improvement in infection management across the Health Board.

The Final Report will set out findings and recommendations for the remaining IPC issues, particularly: clinical governance; the responsiveness of the Health Board's IPC to the infection incidents; the responsibilities and structures of the IPC Team; working culture and relationships with the IPC Team; and the way in which leadership has been organised for IPC.

Local recommendations

- With the support of the Scottish Government and ARHAI Scotland, NHS GGC should undertake a wide-ranging benchmarking of key IPC processes through a more comprehensive Peer Review exercise.
- With the support of ARHAI Scotland, NHS GGC should review its local translation of national guidance (especially the National Infection Prevention and Control Manual) and its set of Standard Operating Procedures to avoid any confusion about the clarity and primacy of national standards.
- With the support of Health Facilities Scotland, NHS GGC should undertake a review of current Healthcare Associated Infection Systems for Controlling Risk in the Build Environment (HAI-SCRIBE) practice to ensure conformity with relevant national guidance.
- With the support of Healthcare Improvement Scotland, NHS GGC should undertake a review of its programme of audits relating to IPC, in line with the national Healthcare Improvement Scotland framework for quality planning and improvement.
- With the support of ARHAI Scotland, NHS GGC should undertake a review of its approach to Healthcare Infection Incident Assessment Tools (HIIATs) to ensure that risks and incidents are being properly and consistently identified and communicated.
- A NHS GGC-wide improvement collaborative for IPC should be taken forward that prioritises addressing environmental infection risks and ensuring that IPC is less siloed across the Health Board.

National recommendations

- ARHAI Scotland should review the National Infection Prevention and Control Manual in light of the QEUH infection incidents.
- Health Facilities Scotland should lead a programme of work to provide greater consistency and good practice across all Health Boards with respect to the use of HAI-SCRIBE.
- ARHAI Scotland should review the existing national surveillance programme with a view to ensuring there is a sustained programme of quality improvement training for

IPC Teams in each Health Board, not least with respect to surveillance and environmental infection issues.

- ARHAI Scotland should lead on work to develop clearer guidance and practice on how HIIAT assessments should be undertaken for the whole of NHS Scotland.

Communication and Engagement

Recommendations are set out below with respect to the overarching question considered by the Oversight Board: *is communication and engagement by NHS GGC adequate to address the needs of the children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?*

Further work is being undertaken on communications and engagement. Issues relating to the organisational duty of candour and review processes such as Significant Adverse Event Reviews will be addressed in the Final Report.

Local recommendations

- NHS GGC should pursue more active and open transparency by reviewing how it has engaged with the children, young people and families affected by the incidents, in line with the person-centred principles of its communication strategies. That review should include close involvement of the patients and families themselves.
- NHS GGC should ensure that the recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy and an accompanying work programme for the Health Board.
- NHS GGC should make sure that there is a systematic, collaborative and consultative approach in place for taking forward communication and engagement with patients and families. Co-production should be pursued in learning from the experience of these infection incidents.
- NHS GGC should embed the value of early, visible and decisive senior leadership in its communication and engagement efforts and, in so doing, more clearly demonstrate a leadership narrative that reflects this strategic intent.
- NHS GGC should review and take action to ensure that staff can be open about what is happening and discuss patient safety events promptly, fully and compassionately.

National recommendations

- The experience of NHS GGC should inform how all of NHS Scotland can improve communication with patients and families ‘outside’ hospitals in relation to infection incidents.
- The experience of NHS GGC in systematically eliciting and acting on people’s personal preferences, needs and wishes as part of the management of communication in these infection incidents should be shared more widely across NHS Scotland.

- NHS GGC should learn from other Health Boards' good practice in addressing the demand for speedier communication in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.
- The Scottish Government, with Healthcare Improvement Scotland and ARHAI Scotland, should review the external support for communication to Health Boards facing similar intensive media events.

Introduction

1. In November 2019, NHS Greater Glasgow and Clyde (NHS GGC) was escalated to Stage 4 of NHS Scotland's National Performance Framework as a result of a continuing series of infection incidents at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). An Oversight Board was established by the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland to address critical issues arising from the operation of infection prevention and control (IPC), clinical governance, and communication and engagement at the QEUH and the RHC.

2. The following Interim Report sets out the findings and recommendations that have been developed to date by this Oversight Board. The report summarises the work on investigation, dialogue and improvement from the Oversight Board's establishment in December 2019 through to October 2020. A Final Report – capturing the results of its remaining programme of work – is due in early 2021.

3. The Oversight Board consists of a group of experts and key representatives drawn from other Health Boards, the Scottish Government and the affected families themselves (full membership is set out in **Annex A**). Chaired by Scotland's Chief Nursing Officer, Professor Fiona McQueen, the work of the Board has been principally carried out through three Subgroups, each focusing on a specific set of issues.

- **Infection Prevention and Control and Governance**: this Subgroup has examined whether or not appropriate IPC and Clinical Governance was (and is currently) in place across NHS GGC and what recommendations are needed to strengthen these. It was chaired initially by Irene Barkby MBE (Executive Director of Nursing, Midwifery and Allied Health Professionals in NHS Lanarkshire), and latterly by Scotland's Deputy Chief Nursing Officer, Diane Murray.
- **Technical Issues**: this Subgroup has focused on the technical workings of the hospitals in question, with a particular focus on key infrastructure issues. It has been chaired by Alan Morrison, Deputy Director for Health Infrastructure in the Scottish Government.
- **Communication and Engagement**: this Subgroup has considered the operation of effective communication with the children, young people and families affected by the infection incidents, as well as whether a wider, robust, consistent and reliable person-centred approach to engagement has been evident. In addition, it is examining the organisational duty of candour and other key review processes, such as the Significant Adverse Event Review policy. It has been chaired by Professor Craig White, Divisional Clinical Lead in the Healthcare Quality and Improvement Directorate of the Scottish Government.

The Terms of Reference for the Oversight Board and its supporting Subgroups are presented in **Annex A**.

4. The Oversight Board and the Subgroups have been aided by a number of special reports commissioned to examine specific issues relating to NHS GGC. Of particular importance for this Interim Report is the **Peer Review of IPC**: led by Lesley Shepherd

(national professional advisor to the Scottish Government) and Frances Lafferty (Senior Infection Control Nurse in NHS Ayrshire and Arran), this examined key IPC systems and processes in NHS GGC and how national policy on IPC has been implemented. Its terms of reference are set out in **Annex B**.

5. Lastly, the work of the Oversight Board was supported by several key individuals appointed to work alongside and within NHS GGC on improvement:

- Professor Marion Bain (Deputy Chief Medical Officer, Scottish Government), who was appointed as the Executive Lead for Healthcare Associated Infection within NHS GGC in December 2019 to set the strategic direction for IPC improvement;
- Professor Angela Wallace (Nurse Director, NHS Forth Valley), who was appointed in February 2020 to work with and succeed Professor Bain as the Health Board's Interim Operational Director for IPC; and
- Professor Craig White, who was appointed by the Cabinet Secretary for Health and Sport in October 2019 to work with the families to address communication issues within NHS GGC (and subsequently, to chair the Communication and Engagement Subgroup).

Their insights informed the Oversight Board's conclusions and their work to date will be set out here and in the Final Report.

6. In parallel, the Cabinet Secretary for Health and Sport commissioned a **Case Note Review** in her statement to Parliament on 28 January 2020. The Case Note Review is examining the individual case documents of the children and young people in the haemato-oncology service from 2015 to 2019 who had a gram-negative environmental pathogen bacteraemia and/or selected other organisms. It is overseen by Professor Marion Bain and a panel of independent external experts led by Professor Mike Stevens (Emeritus Professor of Paediatric Oncology at the University of Bristol). The work of the Case Note Review is continuing and so does not form part of this Interim Report, though there is an update on progress. It is expected to report in early 2021, and its conclusions will be included in the Oversight Board's Final Report.

7. In addition, the Oversight Board has acted alongside to, though separate from the **Independent Review**. On 5 March 2019, Dr Andrew Fraser and Dr Brian Montgomery were appointed by the Cabinet Secretary for Health and Sport to lead an Independent Review with the aim of: "*establish[ing] whether the design, build, commissioning and maintenance of the QEUH and the RHC has had an adverse impact on the risk of Healthcare Associated Infection and whether there is wider learning for NHS Scotland*." The Independent Review's report was published on 15 June 2020.[1] At various points in this Interim Report, the Oversight Board references issues that have been addressed by the Independent Review, but the latter's report is independent of the work of the Oversight Board. NHS GGC and the Scottish Government have both acknowledged the Independent Review's report and are planning action in response to the recommendations.

[1] https://www.queenelizabethhospitalreview.scot/queen-elizabeth-university-hospital-review-review-report/.

8. As with other aspects of public sector activity, the Covid-19 pandemic has proven disruptive to the Oversight Board. From mid-March 2020 onwards, it was not possible to hold regular meetings, as many of its members had vital roles in the NHS Scotland response to the pandemic. This delayed the final stages of the Oversight Board's programme, but it did not substantively alter what was done to reach the findings and recommendations set out here.

9. Following this introduction, the Interim Report consists of several sections:

- **Background and approach**: the context for the establishment of the Oversight Board and the infection issues within the QEUH and the RHC and the way the Oversight Board has been taking forward its work;
- **Infection prevention and control**: a review of the issues that gave rise to escalation to Stage 4, particularly the processes/systems and approach to improvement of IPC in NHS GGC, as well as a description of the remaining work for the Final Report;
- **Governance and risk management**: the full findings on clinical governance will be made in the Final Report, but an update on the work is provided here;
- **Technical review**: the full findings on the technical review will be set out in the Final Report, but a progress update is provided here;
- **Communication and engagement**: a review of the way in which the Health Board communicated and engaged with patients and families and an update on the work to be done for the Final Report;
- **Case Note Review**: an update on progress of this independent examination of the individual children and young people and infection incidents; and
- **Interim Report findings and recommendations**: the findings and initial Oversight Board recommendations of this Interim Report.

10. In addition, there are several annexes:

A. the terms of reference for the Oversight Board and its Subgroups;

B. the terms of reference for the IPC Peer Review;

C. the stages of escalation in the NHS Scotland Board Performance Escalation Framework; and

D. the Key Success Indicators identified by the Oversight Board

Background and Approach

Context for Escalation

11. On 22 November 2019, the decision was taken by Malcolm Wright, Director-General for Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland, to escalate NHS GGC to Stage 4 of the NHS Scotland Board Performance Escalation Framework. In a statement about the establishment of the Oversight Board, the Cabinet Secretary for Health and Sport, Jeane Freeman, said:

> "*Families deserve to have confidence that the places they take their children to be cared for are as safe as they possibly can be. That means their engagement with their Health Board must be open, honest, and rooted in evidence. This is even more important in the tragic circumstances where a child's life is lost. It is, in my view, simply cruel for the grief of a parent to be compounded by a lack of clear answers… I want now to set out the action and steps we are taking to give parents, families and patients the answers they legitimately seek and to, step by step ensure that we are working on evidenced data, putting in place all the required infection prevention and control measures and by doing so secure the confidence of clinical teams, patients and families.*"

12. Escalation came against a background of a series of infection issues affecting children and young people in the paediatric haemato-oncology service at the QEUH and the RHC over a number of years. A handful of cases of children and young people with infections occurred in 2016 and 2017, but concerns mounted between January and September 2018 when the number and diversity of type of infections increased. According to Health Protection Scotland (HPS), there were at least 23 cases, involving 11 different organisms. Water testing in Ward 2A in 2018 identified contamination of water outlets and drains, and as a result, control measures were put in place, including sanitisation of the water supply to Ward 2A and installation of point-of-use filters in wash hand basins and showers. Despite these measures, concerns remained and in September 2018, more drastic steps were taken when Wards 2A and 2B in the RHC were closed and the children and young people were moved to the main QEUH building. Concerns about the water supply led to installation of an enhanced water-testing regime and a chlorine dioxide dosing system, first operating across the RHC in late 2018, then the QEUH in 2019.

13. An additional series of infections in 2019 in Ward 6A in the QEUH heightened concerns, and eventually led to the temporary closure of that ward to new patient admissions. Media reports noted that there had been several deaths of children and young people linked to infection, raising further concerns among patients and families about safety. There was increasing dissatisfaction among some families at the level and quality of communication by NHS GGC throughout this period, leading to the appointment of Professor Craig White by the Cabinet Secretary for Health and Sport in October 2019 as a lead contact and facilitator for the families. In addition, internal NHS GGC reports were coming to light that suggested that some of the problems with the QEUH site had been identified as early as 2015, but did not appear to have been acted upon.

14. This occurred against a background of concerns that had been consistently raised by several clinicians at the QEUH about the potential environmental risks of the building and the link to emerging infections. Some of these concerns dated back to the period of the completion and handover of the new building. Some of the clinicians did not feel that their concerns – particularly about water and ventilation and the risk of their contribution to infection of such a vulnerable patient population – were being effectively addressed, and in some cases, formal whistleblowing procedures were triggered. These issues were raised in correspondence with the Cabinet Secretary for Health and Sport and featured in evidence submitted to the Scottish Parliament's Health and Sport Committee.

15. Finally, there were a number of relevant reports by external bodies over the period that underlined these various concerns. This included the report by HPS, which was invited to examine the infection incidents by the Health Board. Its report – *Queen Elizabeth University Hospital/Royal Hospital for Children: Water Contamination Incident*[2] – was published in February 2019. As well as setting out a number of recommendations for NHS GGC and for national action, the report recognised that the environmental risks of the hospital could not be discounted. Indeed, with the publication of the HPS report, there was extensive media reporting that 'widespread contamination' of the water supply had been found, though the specific link to individual infection incidents remained elusive.

16. Escalation of NHS GGC to Stage 4 was set within the procedure for assessing NHS Board performance. The NHS Scotland Board Performance Escalation Framework lays out the triggers and actions when Health Boards are unable or hindered in taking forward their essential responsibilities. The Framework outlines a guide to inform action, and what steps are needed following the decision to escalate, depend on the 'stage' on the framework. Stage 5 is the most serious stage; Stage 4 is defined as "*significant risks to delivery, quality, financial performance or safety, (and) senior level external transformational support (is) required*." It is applied where the Scottish Government believes that a Health Board's capacity or capability requires enhancement to address local issues, and additional direct management or transformation support may be required. **Annex C** describes the five stages of escalation.

17. The decision to move a Health Board to Stage 4 is made on the advice of the Health and Social Care Management Board of the Scottish Government. In the case of escalation to Stage 4, consideration of the Health Board's position within the Escalation Framework would normally be prompted by the identification of significant weaknesses in particular areas considered to pose an acute risk to the following issues: financial sustainability; reputation; governance; and quality of care or patient safety (or in some cases, by a Health Board failing to deliver on the recovery actions agreed at Stage 3).

18. Action typically takes the form of a transformation team led by a Scottish Government Director, Board Chief Executive or other responsible person appointed by the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland to support the delivery of sustainable transformation. The Health Board Chief Executive continues to act as Accountable Officer and be responsible for matters of resource allocation to deliver any transformation plan. The Board Chief Executive and the executive team are expected to work in conjunction with the appointed transformation Director to construct required plans and take full responsibility for delivery.

[2] https://www.gov.scot/publications/qe-university-hospital-royal-hospital-children-water-incident/.

19. In the case of the escalation of NHS GGC to Stage 4, the transformation Director is Professor Fiona McQueen, the Chief Nursing Officer for Scotland. She has been supported in the programme of transformation by the Oversight Board, and individuals appointed to work within and with NHS GGC, notably Professors Bain, Wallace and White.

20. In February 2020, NHS GGC was escalated again to Stage 4 for a range of issues *beyond* IPC, clinical governance and communication and engagement; these included performance management on waiting times, the Board's out-of-hours service and financial matters. Work on these escalation issues is overseen by a separate Performance Oversight Group, chaired by John Connaghan (interim Chief Executive of NHS Scotland), thought it has had to suspend work as a result of the pandemic. Its programme of work has not informed this Interim Report, although the Oversight Board has been careful not to duplicate areas being covered more thoroughly by this companion group.

The NHS Greater Glasgow and Clyde/Queen Elizabeth University Hospital Oversight Board

21. The purpose of the NHS GGC/QEUH Oversight Board has been to ensure NHS GGC takes the necessary actions to restore and enhance public confidence in safe, accessible, high-quality, person-centred care at the QEUH and RHC with respect to the matters on which the Health Board was escalated. It will advise the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland when steps have been taken – as set out in the Cabinet Secretary's statement in November 2019 – to restore "*confidence that the places families take their children to be cared for are as safe as they possibly can be*." In particular, the Oversight Board will:

i. ensure appropriate governance is in place in relation to infection prevention, management and control;

ii. strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;

iii. improve how families with children and young people being cared for or monitored by the haemato-oncology service have received relevant information and been engaged with;

iv. confirm that relevant environments at the QEUH and RHC are, and continue to be, safe;

v. oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;

vi. provide oversight on connected issues that emerge;

vii. consider the lessons learned that could be applied across NHS Scotland; and

viii. provide advice to the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland and Scottish Ministers about the escalation status of NHS GGC.

22. This Interim Report sets out the Oversight Board's view on the Health Board's progress in addressing several (but not all) of the issues that led to escalation and the work that remains to be done. This is a 'first phase' report; it does not give a final summation of the

Oversight Board's activity and conclusions, which will come in the Final Report. In particular, the Oversight Board has not been able to conclude its work on point **v** in the list above, as the Case Note Review is vital to this, and the Review will not conclude its work until early next year. As a result, the Oversight Board will not examine individual cases or incidents, as these are being covered by the Case Note Review.

23. There are other areas the Oversight Board is not reviewing, particularly where they are being addressed by other processes. In particular, a full accounting of the issues around the building of the hospital is the responsibility of the **Hospitals Public Inquiry**. The Inquiry is chaired by the Right Honourable Lord Brodie QC PC. Its Terms of Reference have now been published[3] and the Inquiry has formally started. The Oversight Board is not pre-empting this work, but has necessarily covered similar territory in some instances as part of its own remit. It has done so with the intention of collecting sufficient evidence to take a view on assurance on NHS GGC's *current* systems, and thereby set out the actions that should be taken to achieve any necessary improvements.

24. Care has also been applied when considering issues raised as part of whistleblowing procedures, which have been activated by some clinicians within NHS GGC in relation to these infection incidents. Much of the substance of the issues raised has been necessary for the Oversight Board to review, and we are particularly thankful for the generous support and courage of those clinicians in raising them. It has been important that the Oversight Board's work does not cut across these whistleblowing processes, and for that reason, the Oversight Board does not offer a view on any specific internal matters directly relating to these procedures.

Key Working Relationships

25. The Oversight Board established three Subgroups with necessary experts and other participants, with the Scottish Government providing the Secretariat. It commissioned a number of key reports to support its programme of work. Overall, the Oversight Board met on nine occasions between December 2019 and March 2020, when meetings were temporarily suspended because of the Covid-19 pandemic. Further meetings took place in September and October to review all of the relevant materials and agree the Interim Report. Each of the Subgroups had a similar calendar of meetings.

26. Relationships with key groups and communities have been vital for the work of the Oversight Board. This has been essential with respect to the families affected by the infections. Representatives of the families have been part of the Oversight Board itself (and the Communication and Engagement Subgroup in particular). In addition, extensive use has been made of the 'closed' Facebook page (described in more detail in the Communication and Engagement chapter below) to update patients and families on the Oversight Board's progress. Professor Craig White provided a central communication role as historical and new concerns were raised during the course of this work.

27. The Oversight Board also established a positive and constructive relationship with NHS GGC – a critical element to ensure that there was joint investigation of relevant issues

[3] https://www.gov.scot/publications/inquiry-into-the-construction-of-the-qeuh-glasgow-and-the-rhcyp-dcn-edinburgh-terms-of-reference/.

and common agreement on how to improve. NHS GGC has worked with the Oversight Board to develop and deliver improvement plans, working through the appointments of Professors Bain and Wallace. NHS GGC staff helped to source and provide a significant amount of information to support Oversight Board and Subgroup discussions, for which the Oversight Board has been particularly grateful. In this context, special mention should be made of the dedicated and highly responsive Programme Management Office set up in NHS GGC to coordinate participation of the Health Board and requests for information. The Programme Management Office offers a good model of how to coordinate and expedite the provision of information, analysis and engagement for such external review processes.

28. NHS GGC staff took part in several meetings of the Oversight Board and its Subgroups as invited participants, although the Health Board representatives were not formally part of these groups. Provision was also made for private discussions by the Oversight Board and the Subgroups where appropriate. The findings and recommendations of this Interim Report are the Oversight Board's alone, though in several cases, they reflect and reinforce actions already being taken by the Health Board. Discussions have been held with the Health Board and extensive feedback provided on the development of the Interim Report.

Governing Principles

29. The work of review and direction in these circumstances can be highly challenging, and given the nature of the subject, sensitive and emotionally charged for the children, young people, families and staff involved. The Oversight Board has adopted a values-based approach in line with the values of NHS Scotland. These values governed the behaviours of the Oversight Board, both individually and collectively to:

- treat all our people with kindness, dignity and compassion;
- respect the rule of law; and
- act in an open and transparent way.

30. Above all, the Oversight Board has been focused on opportunities and requirements for improving existing systems and behaviours. While that needs an understanding of what has happened in the past and how processes operated at different points in the period since the opening of the QEUH, it has all been in the service of assessing the quality and impact of processes in place now. 'History' has been important in reflecting the NHS GGC's own capacity to learn lessons, make any necessary improvements and track the implementation and adequacy of those changes going forward. The Oversight Board has aimed to ensure that learning is captured and implemented locally as well as nationally. It has also highlighted improvements already put in place by the Health Board.

31. The work of the Oversight Board has largely related to a specific patient community within the QEUH, but its focus has widened where larger implications are important to acknowledge. For example, the problems with building the hospital and its links with IPC have potential consequences for other vulnerable patient groups across the site, so assurance has been sought that appropriate actions have been taken on the learning arising from what happened with the paediatric haemato-oncology service.

Priority Issues to Be Examined

32. The Oversight Board has concentrated primarily on structures and procedures and not specific individuals and isolated incidents. These have been central to its role of considering the extent to which assurance can be provided about the Health Board's capability and capacity to deliver on the key areas highlighted in escalation. For the Final Report, the Oversight Board will review the narrative of key milestones to understand the circumstances that gave rise to escalation and provide the essential context for an emerging, progressively more complex set of circumstances. For the key areas it was examining – IPC, clinical governance, and communication and engagement – the Oversight Board set out what 'good looks like' through a set of key success indicators (the full set of indicators is described in **Annex D**). The aim has been to concentrate on a set of principles for each area that governed how the Oversight Board and its Subgroups pursued investigation and recommendation. These principles have been applied through a focus on a set of overarching questions:

- ***To what extent can the source of the infections be linked to the environment and what is the current environmental risk?***
- ***Are IPC functions 'fit for purpose' in NHS GGC, not least in light of any environmental risks?***
- ***Is the governance and risk management structure adequate to pick up and address infection risks?***
- ***Is communication and engagement by NHS GGC sufficient in addressing the needs of the children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?***

33. These questions are threaded through the issues considered in the Interim Report. This report does not make final conclusions on these questions, but a full assessment will be included in the Final Report. The questions also link the key areas that the Oversight Board has been tasked to review in the context of these infection incidents:

- **IPC**: the processes, structures, relationships and behaviours in place to ensure that there is effective identification of infections, management of outbreaks and incidents, and appropriate preventative and improvement work around these issues;
- **clinical governance**: the framework and systems in place for the issues and risks associated with infections to be raised and actioned, and the assurance secured within the organisation's senior management that this is happening; and
- **communication and engagement**: how the issues and implications of incidents and outbreaks are communicated with the children, young people, families and the wider public in line with the person-centred principles of NHS Scotland.

34. The issues are inter-locking. Robust IPC procedures should highlight major issues and risks through the structure of governance and risk management. Strong clinical governance will give clear direction and resourcing to IPC across the organisation and ensure a culture of transparency and responsiveness to patient, family and public concerns. Good communication and engagement should ensure that the decisions with governance and the actions taken forward through the IPC Team are clearly presented to those affected by them.

35. Each set of issues required dedicated assessments. For **IPC**, the Oversight Board considered NHS GGC practice in light of the infection incidents with reference to two key principles, as set out in its key success indicators:

- *There is appropriate governance for infection prevention and control in place to provide assurance on the safe, effective and person-centred delivery of care and increase public confidence.*
- *The current approaches that are in place to mitigate avoidable harms, with respect to infection prevention and control, are sufficient to deliver safe, effective and person-centred care.*

36. Similarly, for **communication and engagement**, the key success indicators that the Oversight Board have used are that:

- *Families and children and young people within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of the NHS Scotland in full.*
- *Families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHS Scotland in full.*

The Oversight Board's findings and recommendations should be seen through the 'lens' of these key success indicators.

37. As noted above, the findings and recommendations will be reported across two reports: this Interim Report; and a final Report. Different issues relating to escalation will be covered by the Interim and Final Reports: the table below sets out what issues will be covered by which report.

Escalation issue	What is covered in this Interim Report	What will be covered in the Final Report
Infection prevention and control	• Assurance on a selection of IPC processes/systems in NHS GGC following Peer Review • Review of approach to improvement in IPC in NHS GGC • Findings and recommendations on the above set of issues	• Review of how the infection incidents were addressed by NHS GGC and wider mitigation/responses • Review of the roles, resourcing, organisation and related culture and leadership issues of the IPC Team for the QEUH • Findings and recommendations on the above set of issues
Clinical governance	• Update on work on Clinical Governance	• Review of how infection incidents were escalated and addressed by the NHS GGC governance structure • Assurance on how IPC issues are currently escalated and addressed within NHS GGC • Review of NHS GGC risk management in light of the infection incidents • Findings and recommendations on Clinical Governance issues
Related technical issues	• Update on refurbishment of Wards 2A/2B in the RHC	• Assurance on NHS GGC's water testing policy in the RHC/QEUH • Assurance on plans to address any remedial works relating to infection arising from infrastructure issues on the QEUH site
Communication and engagement	• Review of how communication and engagement was undertaken by NHS GGC with the children, young people and families affected by the infection incidents – including findings and recommendations	• Review of how the organisational duty of candour, the Significant Adverse Events Policy and related review processes operated for these infection incidents – including findings and recommendations
Escalation issue	**What is covered in this Interim Report**	**What will be covered in the Final Report**
Case Note Review	• Update of the work of the Case Note Review	• Summary of findings and recommendations of the Case Note Review
Review of escalation to Stage 4		• Advice on whether/how de-escalation should take place

38. The Oversight Board is conducting its work through the review of key documentation and direct inquiry with NHS GGC involving the experts who took part in the Oversight Board and its Subgroups. For the Interim Report, evidence included:

- the papers and material presented by NHS GGC to the meetings, including minutes of the Board, relevant committees (such as the Board Infection Control Committee and the Clinical and Care Governance Committee) and Incident Management Teams (IMTs), relevant action plans, special presentations and 'situation, background, assessment, recommendation' papers (SBARs);
- material provided previously to the Cabinet Secretary for Health and Sport by several clinicians;
- specially-commissioned, topic-specific SBARs from external experts and statements on specific issues, such as water testing and the progress of refurbishment of Wards 2A and 2B in the RHC; and
- key external documents, such as the Health Facilities Scotland (HFS) report, *Water Management Issues Technical Review: NHS Greater Glasgow and Clyde – Queen Elizabeth University Hospital and Royal Hospital for Children* (finalised March 2019), and the HPS report, *Summary of Incident and Findings of the NHS Greater Glasgow and Clyde: Queen Elizabeth University Hospital/Royal Hospital for Children Water Contamination Incident and Recommendations for NHSScotland* (published February 2019).

39. There was no programme of comprehensive interviewing or evidence gathering from individuals and organisations, apart from what was undertaken for commissioned work such as the Peer Review described above. However, specific clarifying discussions were held with some QEUH clinicians that had raised concerns about the Health Board, representatives of the affected children, young people and families, and NHS GGC representatives throughout the Oversight Board's programme of work.

Infection Prevention and Control

40. Long before the recent incidents at the QEUH, IPC procedures in hospitals had been under a spotlight. Following an outbreak of *Clostridium difficile* infection at the Vale of Leven Hospital within NHS GGC, which led to the deaths of 34 patients, the Scottish Government established an Inquiry under Lord MacLean to investigate not just *C. difficile* infection, but all deaths at the hospital associated with this infection in the period between 1 December 2007 and 1 June 2008. Its final report was published in November 2014[4], and found, amongst other things, that:

- governance and management failures within NHS GGC had created an environment in which patient care was compromised and the approach to IPC was inadequate;
- there were significant deficiencies in IPC practices and systems which had had a profound impact on the care provided to patients in the hospital; and
- strong management was lacking, which contributed to a culture unsuited to a caring and compassionate hospital environment.

41. NHS GGC accepted the recommendations, which included the following of particular relevance to the Oversight Board's work (not all directed exclusively at the Health Board, but across NHS Scotland more widely):

- *In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment, should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular review s of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.*
- *In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.*
- *Health Boards should ensure that IPC policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart;*
- *Health Boards should ensure that all those working in a healthcare setting have mandatory IPC training*;
- *Health Boards should ensure that the Infection Control Manager (ICM) has direct responsibility for the IPC service and its staff*;
- *Health Boards should ensure that the ICM reports direct to the Chief Executive or, at least, to an executive board member*;

4 https://webarchive.nrscotland.gov.uk/20170401011220/http://www.valeoflevenhospitalinquiry.org/report.aspx.

- *Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings*;
- *Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time*; *and*
- *Health Boards should ensure that IPC groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.*

42. The Vale of Leven Inquiry provides important context here. Not only did the Health Board set out plans to implement all the relevant recommendations, but the recommendations as a whole helped to shape the development of national standards and the current framework for IPC across NHS Scotland. This culminated with the issuing of the key guidance letter, DL (2019) 23 in December 2019[5] by the Chief Nursing Officer of NHS Scotland. This set out the mandatory Healthcare Associated Infection (HCAI) and Anti-microbial Resistance (AMR) policy requirements for all NHS Scotland healthcare settings. As the letter noted:

> "*Despite the progress made over recent years, reducing HCAI and containing AMR remains a constant challenge. Therefore, it is important at both a national and NHS Board level and beyond, that there is ongoing and increased monitoring for accurate, and, as far as is possible, real time assessments of current and emerging threats*."

43. This background of increasing sensitivity to the need for ever-more robust IPC procedures and the drive for improvement form an important backdrop for the Oversight Board's work. In its terms of reference, the Oversight Board recognised that there would be key points of learning and need for improvement for both NHS GGC individually as well as for NHS Scotland as a whole. In this context, it is important to understand the distinctive circumstances of what took place in the QEUH.

- **The unique circumstances of a modern, large hospital**. There was little precedent for the challenges arising from a large, newly-built hospital complex such as the QEUH – not least in understanding the scale and nature of the infection issues and the diversity of organisms that appeared. This manifested itself in the limited experience that NHS GGC – and NHS Scotland more widely – could draw upon to fathom the particular issues relating to infection in the context of a modern hospital such as the QEUH. Indeed, there are few comparators whose experience on which the Health Board has been able to draw. This context is by no means justification for any of the actions taken – or not taken – as standards should rightfully be expected to be met in all healthcare settings. However, it is essential for understanding how NHS GGC had to adapt to an often novel, and in many respects, 'non-textbook' situation. Recognition of this is important, not least from the perspective of the national learning the Health Board's experience can provide going forward.

[5] https://www.sehd.scot.nhs.uk/dl/DL(2019)23.pdf.

- **The scale of the Health Board**. The issue of NHS GGC's unique scale as the largest Health Board in Scotland (and one of the largest in Europe) is relevant, as the sheer size and expanse of the Health Board were defining features for some of its approach to these issues. For example, IPC responsibilities are divided between a number of different geographical teams, each covering a mixture of hospitals and other healthcare settings. The Oversight Board's comments are largely focused on the operation of processes at the QEUH. At no point was the issue of scale ever offered as a mitigating or explanatory factor for how the Health Board should have fulfilled its responsibilities in the circumstances under review. However, it was cited as a factor at points in how the Health Board did and could have responded to the circumstances and what might be improved going forward.
- **Focus on selected aspects of IPC**. Throughout the Oversight Board's work, there were many good examples presented of a range of IPC functions in NHS GGC. As a result, it is important to separate out issues that applied specifically to the particular infection incidences under review – both in terms of the specific site (the QEUH) and the specific patient group (those in the paediatric haemato-oncology service) – and those which applied more widely to how IPC was pursued across NHS GGC as a whole. For example, the Oversight Board did not set out to examine the experience, responsibilities and processes in place for dealing with the bulk of gram-*positive* infections, and the steps that the IPC Team and other staff had taken to eradicate their transmission (such as approaches to hand cleanliness). This is especially important in understanding the Oversight Board's focus on IPC in the context of environmentally-related infections (which includes both gram-negative and positive organisms). Consequently, the Oversight Board did not examine the full range of IPC functions in NHS GGC, only those directly relevant to these particular incidents.

44. At the same time, there is a **historical context** that should be understood. While not delving into these issues, as already noted, the Oversight Board recognised that there were significant shortcomings in: the construction and handover of the QEUH; and how NHS GGC responded to emerging and related problems. These include the concerns that were raised by a number of clinicians at an early stage as well as how 'warning signals' about potential problems were – or were not – acted upon over the years. The Oversight Board discussed these issues, but they have only been highlighted where they: remained a continuing and current factor that would compromise any assurance on the issues relating escalation; or were corrected and led to improvements that are important to acknowledge. It is recognised that relationships and trust were impacted as part of these historical issues, resulting in the early decisions to appoint Professors Marion Bain and Angela Wallace in key positions within the Health Board to take forward urgent work.

45. Ultimately, the Oversight Board has sought assurance that current IPC processes within NHS GGC are 'fit for purpose': in terms of national standards and good practice and in light of how they addressed the infection incidents of the last few years. In this respect, the Oversight Board has measured Health Board IPC against the key success factor: "*the current approaches that are in place to mitigate avoidable harms, with respect to IPC, are sufficient to deliver safe, effective and person-centred care*" (see **Annex D**). Consequently, the Oversight Board commissioned a range of work. As part of this programme, the Oversight Board has:

- commissioned a detailed description of the timeline of infection incidents between 2015 and 2019 and formal meetings to address the incidents (this will be presented in full in the Final Report);
- commissioned a system-wide Peer Review of current IPC systems and processes and associated governance scheme of delegation and escalation mechanisms against relevant national standards and guidance;
- commissioned bespoke SBARs on particular issues, such as the use of HIIATs by the Health Board;
- received reports from key individuals placed within NHS GGC, particularly Professors Bain and Wallace; and
- assessed if there were any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to operational delivery of IPC, including staffing/resourcing, minimum skills and joint working between relevant units.

46. As noted already, some work could not be done in full due to curtailment caused by the Covid-19 pandemic. Nevertheless, the Oversight Board amassed sufficient evidence to set out a series of findings in the following key areas:

- **Processes and systems**: the degree to which specific IPC processes and systems in the QEUH have been aligned with national standards and good practice and their effective and reliable implementation; and
- **Approach to improvement**: the extent to which the IPC Team has demonstrated a sustained commitment to improvement, and acted as an agent for improvement in infection management across NHS GGC.

Processes and Systems

47. A critical element of the work of assurance by the Oversight Board is IPC processes and procedures within the Health Board. National compliance is important, not least given the efforts in recent years to codify good practice in IPC in the wake of the Vale of Leven Inquiry. There is a recognisable balance between compliance in national standards with flexibility in applying local innovation/ improvement, but as with much healthcare, fidelity in crucial areas is important.

48. To examine in greater detail the way that IPC operated within NHS GGC, a Peer Review was commissioned by the Oversight Board to explore some processes and procedures in more forensic detail. This exercise was designed to gain an understanding of how IPC systems and processes were embedded. The objectives of the Review were to:

- investigate the ways in which IPC at NHS GGC is operationalised across the system; and
- determine the ways in which national policy has been implemented within NHS GGC, identifying areas where this was carried out and where it could be improved.

The focus has been on the current operation of these processes.

49. Several areas of focus were originally identified for the Review, but owing to the restrictions caused by the Covid-19 pandemic, only the following could be taken forward:

- implementation of the National IPC Manual (NIPCM);
- implementation of Healthcare Associated Infection Systems for Controlling Risk in the Built Environment (HAI-SCRIBEs);
- audit;
- surveillance; and
- the use of the Healthcare Infection Incident Assessment Tools (HIIATs).

Action on two other areas – outbreak and incident investigation, and water safety – could not be taken forward through this Peer Review as planned, but are still recommended to be examined at some stage.

50. A team comprising members of the IPCG Subgroup was established to undertake the Peer Review. The Peer Review was undertaken on 16 March 2020 by Lesley Shepherd (national professional advisor to the Scottish Government) and Frances Lafferty (Senior Infection Control Nurse in NHS Ayrshire and Arran). Additionally, the Oversight Board requested Anti-microbial Resistance and Healthcare Associated Infection (ARHAI) Scotland to undertake an assessment of NHS GGC reporting of Healthcare Infection Incidents on the QEUH site. The focus of the SBAR was specifically on how HIIATs were used.

Application of the National IPC Manual

51. As set out above, over the last few years there has been significant work nationally to set a common approach to improvement and standards in IPC. Central to this has been the NIPCM. Published in 2012[6], the National Manual sets out the standards, good practice and resources for improvement for IPC across NHS Scotland. Alignment between Health Board practice and the NIPCM reflects a Health Board's commitment to a recognised, consensus set of practices associated with 'what good looks like' for IPC. The NIPCM aims to:

- facilitate the effective application of IPC precautions by appropriate staff;
- reduce variation and optimise IPC practices throughout Scotland;
- improve the application of knowledge and skills in IPC;
- reduce the risk of HAI; and
- help alignment of practice, education, monitoring, quality improvement and scrutiny.

52. The National Manual is central to the Health Board's approach to IPC – indeed, NHS GGC placed the NIPCM as a link on the IPC Portal on its intranet site. In addition, the IPC Team has developed a series of new 'Standard Operating Procedures' (SOPs) to supplement national guidance for the Health Board – NHS GGC described these as a way of 'operationalising' the NIPCM, making it easier for frontline staff to understand the Manual.

53. However, as the aim of the NIPCM has been to "*make it easy for care staff to apply effective infection prevention and control precautions*", it was not clear to the Peer Review team why NHS GGC has developed so many SOPs. These typically require regular updating

[6] http://www.nipcm.scot.nhs.uk/.

based on the current scientific evidence reviews within the NIPCM. The SOPs do not provide contradictory information – they reflected national advice – but given that this work has already been undertaken as part of the NIPCM, the production of the SOPs seems to be unnecessary, if not redundant.

54. Moreover, the NHS GGC IPC Portal does not differentiate between local SOPs and the NIPCM. This is likely to cause confusion as to what constitutes national policy and what, local guidance. Moving forward, NHS GGC must ensure that staff are directed initially to the NIPCM and that SOPs should only be provided where there is a clear, compelling justification for their added value.

55. Nevertheless, there are some SOPs that *should* be developed going forward. In particular, disease-specific SOPs or aide-memoires would be a useful tool for facilitating easy access to key IPC information supported by the NIPCM. This could be important for novel and emerging pathogens which were linked to significant outbreaks of infection. The NIPCM includes information around transmission-based precautions required for specific pathogens/conditions within its Appendix 11, but there is a national need for extra guidance. It would be appropriate for some additional disease-specific, evidence-based SOPs/aide memoires to be produced nationally for inclusion within the NIPCM as part of national work.

Use of Healthcare Associated Infection Systems for Controlling Risk in the Built Environment

56. HAI-SCRIBE implementation was chosen as part the Peer Review to illuminate the wider issues of IPC governance being considered by the Oversight Board. HFS published the Scottish Health Facilities Note (SHFN) 30[7] in January 2007 to support Health Boards to manage IPC in the built environment. The guidance comprised:

- Part A – the National Manual, which provides information for teams to support decision making so that identified risks can either be eliminated or successfully managed; and
- Part B – the HAI-SCRIBE Implementation Strategy and Assessment Process, which supports built environment project groups to identify, manage and record built environment infection control risks.

The main aim of the guidance is to ensure that IPC issues are identified, analysed and planned for at all stages of a project in the healthcare built environment. HAI-SCRIBE ensures that IPC measures are designed as part of plans and can be maintained throughout the lifetime of the healthcare facility.

57. The Peer Review team found that while this process is largely adopted within NHS GGC, there are inconsistencies. When both the Facilities and Estates staff and Lead Infection Control Nurses (LICNs) were asked if there was a consistent and systematic approach to HAI-SCRIBE risk assessment across NHS GGC, their answers differed: Facilities and Estates representatives stated that there was, while the LICNs said there was not. Moreover, a review of a selection of completed HAI-SCRIBE documents highlighted:

[7] file:///C:/Users/u206386/Downloads/1509104776-SHFN%2030%20Part%20A%20-%20HAI-SCRIBE%20Manual%20information%20(1).pdf.

- inconsistencies in approach regarding levels of work, patient risk categorisation and subsequent control measures required to mitigate risk to patients;
- evidence of involvement of the IPC Team in compiling the document, when it was often the responsibility of the relevant Estates Manager;
- inconsistencies within the documentation in terms of the type of work and control measures as well as those personnel involved in the document completion – for example, the names of those involved were found on the front of the HAI-SCRIBE document, however, at the foot, there were no signatures and on occasion, a different LICN noted; and
- an impression that several had been 'cut and pasted' from previous HAI-SCRIBE documents.

58. Good practice is clear that this should be a joint responsibility between Facilities and Estates and IPC Team staff, ensuring that the approach to reporting does not become siloed and relevant expertise and judgement is systematically and appropriately deployed.

Approach to Audit

59. In 2018, HPS issued the National Monitoring Framework for Safe and Clean Care Audits[8], which provides an agreed, recommended minimum approach to auditing for all Health Boards. This gives a set of principles for the quality assurance of all Safe and Clean Care auditing while supporting a Quality Improvement (QI) approach for compliance and improvement. The Framework clearly defines where the responsibility for undertaking audits, developing action plans and taking forward actions to address any issues lies. It stresses that IPC within Health Boards is *not* the sole responsibility of IPC Teams, but also falls to local teams, and is underpinned by organisational governance structures which ensure strategic oversight.

60. The audit process within NHS GGC has been recently updated in line with the National Monitoring Framework for Safe and Clean Care Audits. A bespoke, quality dashboard has been developed to provide an overview of other quality metrics which can impact staff's ability to undertake good IPC practice, such as staffing levels and patient acuity. The dashboard can show a breakdown of information by each individual clinical area. Senior Charge Nurses have access to the dashboard for monitoring quality within their area and are owners of their local improvement plans.

61. Audits employing IPC Audit Tools (IPCAT) are undertaken using a collaborative approach to enable the appropriate individuals to take ownership of relevant actions and respond accordingly. Facilities and Estates teams are involved in audit processes in some areas, but there is no standard specifying who should be involved in the audit process at local level. A Combined Care Assurance Audit tool is currently being developed, which is expected to further strengthen collaborative working. NHS GGC reported that the IPCAT audit report and action plan are shared with ward staff, and discussed during ward huddles

62. IPCAT audits reflect a point in time and give a snapshot of IPC policy. The audit alone does not improve compliance – this must be achieved through a change in behaviours, adaptations to practice or processes and, where required, repairs/alterations to the built

[8] http://www.nipcm.hps.scot.nhs.uk/resources/audit-tools/.

environment. Investigatory management beyond the immediate correction/action is essential if sustained change is to be achieved. Action plans arising from IPC need to use a quality improvement approach with local teams reviewing current systems and processes and agreeing, testing and implementing change ideas with improvement progress regularly assessed via local data collection.

63. It is not evident from either the IPCAT strategy or discussion with the IPC Team how local improvement is measured other than by undertaking a re-audit at set intervals based on the RAG status. The use of audits to drive improvement does not appear to be fully embedded in the relevant action plans, suggesting that there is a disconnect between the process of audit and follow up and the wider goals of improvement those processes should be supporting.

Approach to Surveillance

64. Surveillance is crucial in order to gather intelligence to identify HAIs and outbreak clusters, and facilitate rapid action to address them. National guidance sets out a requirement that organisations have a surveillance system to ensure a rapid response to HAI.

65. NHS GGC uses the IPC clinical surveillance platform, ICNet, to record surveillance data. ICNet is designed to enable a comprehensive approach to clinical surveillance, outbreak management and anti-microbial stewardship, and is customisable to the specific requirement of the user. Having used the system for a number of years, it appears that the system is effective in NHS GGC. The IPC Team in NHS GGC includes data analysts, who support data collation and outputs of surveillance enabling the Infection Control Nurses (ICNs) to focus on their clinical remit.

66. During the Peer Review, issues were raised about how regularly the triggers and organisms in ICNet system are updated regularly. For example, Appendix 13 of the NIPCM[9] is a nationally-agreed minimum list of alert organism/conditions with the purpose of alerting Health Board IPC Teams and Health Protection (HP) Teams of occurrences which may require further investigation. Unless otherwise stated, a single case would require an IPC or HP Team review to advise that the correct IPC measures were in place to reduce transmission risk. Typically, two or more linked cases should trigger further investigations into a possible outbreak. The list provided in Appendix 13 of the NIPCM is not exhaustive and specialist units – such as bone marrow transplant or cystic fibrosis – will also be guided by local policy regarding other alert organisms pertinent to these areas.

67. The Peer Review team understood that despite previous infection outbreaks within NHS GGC, the only additional environmental alert organisms added to their ICNet system (other than those within Appendix 13) were *C.pauculus* and *Cryptococcus*. This meant that the IPC Team had been purely reliant on laboratory surveillance alerting them to the presence of other environmental gram-negative isolates within patient specimens. Given the history of outbreaks, the diversity of environmental organisms seen and the rare nature of some of the organisms, a more pro-active approach to surveillance would have given a more systemic early-warning system given the recurrence of infections.

Use of Healthcare Infection Incident Assessment Tools

[9] http://www.nipcm.hps.scot.nhs.uk/media/1365/2017-06-19-appendix-13.pdf.

68. The NIPCM sets out the requirements for NHS Boards to assess all healthcare infection incidents using the HIIAT. An early and effective response to an actual or potential healthcare infection incident or outbreak is crucial. The local Health Board's IPC and HP Team should be aware of, and refer to, the national minimum list of alert organisms/conditions set out in Appendix 13 of the NIPCM. Within hospital settings the IPC Team normally take the lead in investigating and managing any incidents with support from the HP Team. Every healthcare infection incident in any healthcare setting should be assessed using the HIIAT.

69. In reviewing the HIIATs reported to ARHAI Scotland (formerly part of HPS), particular attention was given by the review team to 'green'-rated incidents. Incidents reported as 'green' have been provided to HPS/ARHAI Scotland 'for information only' with no escalation required to the Scottish Government. These are all reviewed by a Senior Infection Control Nurse within ARHAI Scotland and further information has been sought from the reporting Health Board where the assessment and scoring of the incident appears inconsistent with the HIIAT tool guidance.

70. A number of the 'green' incidents reported by NHS GGC over the period had been challenged by HPS/ARHAI Scotland. There were questions raised about whether the 'green' ratings were appropriate and how the recurrence of environmental infections within the QEUH site had been factored into the rating. HIIAT assessments rely on individual review and judgements that are necessarily subjective. Indeed, the ARHAI Scotland review of HIIATs for the Oversight Board noted some variation between different assessments across all Health Boards. But with respect to NHS GGC, several HIIAT assessments did not seem to take sufficient account of previous incidents within the same hospital site. Assessment should not focus exclusively on individual occasions of infection, but take into consideration wider backdrop issues. Indeed, there had been cases when HPS/ARHAI Scotland requested the Health Board to reassess an incident, taking into account previous incidents, although NHS GGC often chose not to change its initial assessment.

71. ARHAI Scotland concluded that there is a need for national as well as local learning here. *Context* should be a key element in the application of this alert system, a recognition that incidents may assume a different significance when considered in light of any potential pattern of infection incidents faced by the Health Board and the possibility of links to the environment. Opportunities for intervention by the Health Board as a consequence of taking a wider view of infections may have been lost. As a result, there is need for a deeper investigation of how NHS GGC continues to rate its infection incidents in the QEUH going forward.

Approach to Improvement

72. A systematic approach to healthcare improvement and better IPC have been ever more closely linked in recent years. Indeed, the Scottish Patient Safety Programme, which has embedded a more comprehensive improvement ethos across NHS Scotland, was in large part a response to the implications of the Vale of Leven Inquiry. Health Boards should not only be fulfilling current operational duties with respect to IPC, but ensuring that actions are taken to support improvements in their approach.

73. Improvement is explicitly highlighted within the overarching IPC guidance in NHS GGC, but it is not a responsibility lodged in a single part of the organisation. As set out in the Health Board's own Governance and Quality Assurance Framework for IPC Services, the IPC Team is responsible for, amongst other things:

- ensuring advice on IPC is available;
- in liaison with other relevant staff preparing, reviewing and updating evidence-based policies and guidelines in line with relevant UK Department of Health notifications and/or guidelines, when available and applicable;
- ensuring the provision of appropriate education to all grades of staff working within the scope of the policy; and
- providing specialist advice to key committees, groups, departments or individual staff members in relation to IPC practice.

Consequently, the role of the IPC Team is not standalone, but part of the wider conduct of Health Board responsibilities, recognising that IPC can only be successfully carried out when it is embedded across NHS GGC and driven by a commitment to continuous improvement. The IPC Team has the central role in this process of mainstreaming – in effect, ensuring that IPC is not just the responsibility of the IPC Team.

74. Based on international work undertaken between the Institute of Healthcare Improvement in Boston and Healthcare Improvement Scotland, the Model for Improvement (MFI) is the most widely used improvement methodology used within healthcare in Scotland. The MFI asks three questions:

- *what are we trying to accomplish* (aim);
- *how will we know that change has made an improvement* (data collection); and
- *what change can we make that will result in improvement* (change ideas).

These can be laid out in terms of the improvement journey which outlines the stages on an improvement initiative or project. Successful change occurs when there is commitment, a sense of urgency or momentum (for example, higher infection rates), stakeholder engagement, openness and a clear vision that is communicated well. Involvement of those people in the system is vital to success as they understand the system better than anyone else as development of change ideas will come from their experience of the local practice. These changes require: small-scale, iterative testing ('plan, do, study act', or PDSA); refining and adapting these using the knowledge from each successive test and all the time gathering data to indicate whether change is resulting in improvement. Once the local team is confident that the process change is improving outcome, then and only then, should wholesale local implementation commence.

75. As an agent of Board-wide improvement change, there are excellent examples of this kind of change in NHS GGC. One good example is the quality improvement project to reduce the central line-associated bloodstream infection (CLABSI) rate in the paediatric haemato-oncology population.

Quality improvement to reduce the CLABSI rate in paediatric haemato-oncology

From 2017, the Health Board undertook an exercise to improve infection rates and infection prevention behavior in the paediatric haemato-oncology unit. Surveillance data showed

fluctuations in CLABSI rates in the Schiehallion Unit. Before de-canting to QEUH wards in September 2018, Ward 2A in the RHC was a haemato-oncology unit and housed the National Bone Marrow Transplant Unit as well as the Teenage Cancer Trust. Ward 2B was the daycare component of Ward 2A. Staff began researching evidence on the topic and found benchmarking guidance from the Cincinnati Children's Hospital in the US. This led to a project focused on simple changes for better patient outcomes and on a hospital-wide Quality Improvement Collaborative (QIC) set on reducing the incidence of CLABSI across the hospital. Elements of the QIC included giving staff across the unit responsibility of management of line incidence reporting within 48 hours and unified central line insertion protocols.

The methodology was applied with a specific, measurable target: to reduce the number of CLABSIs in Schiehallion Unit patients to 1 per 1,000 total line-days. This was supported by a clearly-defined driver diagram with primary and secondary drivers defined by tailored measurements, and a set of successful outcomes.

Key outcomes

- An issue identified and acted on using QI methodology locally led with support and reporting through Health Board structures
- CLABSI rate reduced and stabilised: from a rate of 6.33 in June 2017 to just over 1 by the start of 2020
- Almost 80 percent reduction from peak phase and just under 60 percent reduction from baseline
- Benchmarking 'like-for-like data' challenging, however, best in country when compared to similar paediatric units
- Going forward – focused on improvement of services continuous improvement, shared learning

76. Across NHS GGC as a whole, there are other instances of IPC focusing on improvement. For example, with respect to gram-*positive* infections, there is notable performance against national expectations. The Clinical Outcomes Review commissioned by the Chief Executive as part of a trio of stocktaking reports on the QEUH, and which reported to the Board at its meeting in October 2019, concluded: "*both internal and external review of available data indicates the QEUH and the RHC are not outliers in terms of rates of Healthcare Associated Infection (HAI) or practice*."[10] Timeous and effective action across NHS GGC was also evident in responding to individual infection issues, as the Oversight Board saw in the case of the 2019 *Stenotrophomonas maltophilia* outbreak at the Royal Alexandria Hospital in Paisley.

2019 infection outbreak at the Royal Alexandria Hospital

A number of instances of *Stenotrophomonas maltophilia* were identified at the Royal Alexandra Hospital in Paisley in early 2019. Infections in previously healthy patients are typically unusual. Nosocomial infections (ie. originating in a hospital) has been increasingly recognised, and usually only occur in those with significantly-impaired immune defences, such as severely immuno-compromised patients. This can cause bloodstream, respiratory,

[10] www.nhsggc.org.uk/media/257579/item-14-int-review16decfinal.pdf.

urinary and surgical-site infections. Risk factors pre-disposing a hospitalised patient towards infection include prior exposure to anti-microbials (especially broad-spectrum antibiotics), mechanical ventilation and prolonged hospitalisation. It may also affect the lungs of patients with cystic fibrosis.

S. maltophilia is resistant to many antibiotic classes. This means that treatment options are relatively limited. However, most strains remain susceptible to co-trimoxazole which is regarded as the drug of choice for treating infections. In January 2019, the IPC Team was informed of three instances related to *Stenotrophomonas*, which led to an IMT being convened by the end of the month. The Board was updated via the Healthcare Associated Infection Reporting Template (HAIRT) in February, and further updates were provided to the Care and Clinical Governance Committee, the Board Infection Control Committee and the Acute Infection Control Committee in March.

When the outbreak took place, a robust structure was in place which meant the incidents were managed timely and effectively at all stages. The key outcomes were:

- timely management of the incident and establishment of multidisciplinary team improves outcomes and communication;
- strict adherence to IPC procedures to reduce the risk of transmission of infection;
- communication with patients and families was pursued as a central part of incident management and managed by the clinical team with support from the IMT;
- a recognition that roles and responsibilities in environmental sampling needed to be clarified; and
- information flow from Reference labs needed to be streamlined.

77. What was notable in the above incident was the highlighting of the ‘lessons learned’ and the determination that relevant improvements were made in the local IPC Team (although there was no evidence presented that these lessons learned were shared across the different IPC teams in the Health Board). The Oversight Board saw abundant evidence of the hardworking and diligent nature of the staff in this area, with commitments to improving outcomes and ensuring patient safety and better care.

78. It is clear that the Health Board could learn from the experience of its infection incidents and adjust accordingly its approach, structures and actions, especially from 2018 onward. This was notable in several key developments (as discussed in more detail elsewhere in this Interim Report and in the Final Report): the establishment and active work of a Technical Water Group to provide a targeted response to the set of 2018 infections; the updating of NHS GGC’s Water Safety Policy in 2018; the development of a single IPC Assurance and Accountability Framework from a set of separate documents; and the new SOP relating to the identification of new environmental organisms agreed in November 2018.

79. Nevertheless, these instances did not appear to be part of a more systematic approach to learning led by the IPC Team. Apart from a handful of commendable but seemingly isolated examples, there did not appear to be a sustained approach to IPC improvement across the Health Board. It was a recurring theme of the issues examined by the Peer Review and the approach taken to HIIATs discussed above.

80. For example, as part of the work of the Peer Review, the investigating team asked NHS GGC for examples of how local surveillance data was used to inform quality improvement work. The IPC Team has been involved in much of the quality improvement work that was cited, including development of Peripheral Venous Cannula (PVC) care plans which supported frontline staff in undertaking the correct, evidenced-based care of PVCs. This work was led by the IPC Team without implementation of the model for improvement – consequently, ownership of the required improvement was not taken up by the clinical teams or services. There was no evidence of a structured use of quality improvement methodology and importantly, it was not evident that the relevant local teams were leading this work. Put simply, improvement work appeared to be siloed within the IPC Team without sufficient mainstreaming across other teams.

81. Similarly, the role of the IPC Team in producing guidance and policy raised concerns. In addition to the individual standard infection control and transmission-based precautions, there were a number of other SOPs that seemed to have been produced principally by the IPC Team. One example was a SOP Team for the insertion and maintenance of urethral urinary catheters – as catheter insertion and maintenance is typically the role of local bowel and bladder teams, the role of the IPC Team in leading the drafting of this SOP was confusing. Whilst the IPC Team should support and advise this work, it is inappropriate for them to lead. Indeed, it was not clear whether the local bowel and bladder reference group was involved in this work.

82. This does not reflect an IPC service which is integrated and collaborative. It appears to be one that provides a standalone service rather than advises and works towards the mainstreaming of IPC improvement. The ethos of improvement should be to work together across existing professional and organisational boundaries when the opportunity to find better ways of delivering shared outcomes can be achieved. That approach was inherent in the CLABSI work described above and should be more systematically pursued across the IPC Team.

83. In this context, the new IPC improvement collaborative being established through work led by Professor Angela Wallace is welcomed. This collaborative should encompass explicit learning from the QEUH infection incidents, not least with respect to handling gram-negative bacteria infections and working against the background of a potentially-compromised building. The recent refocusing of Executive responsibilities within NHS GGC around a ‘Gold Command’ structure – led by the Health Board’s Chief Executive – and the creation of a new strand of transformation activity on ‘Better Safe, Clean Clinical Environment’ under the leadership of the Interim Deputy Director for IPC, the Chief Operating Officer and the Director of Facilities and Estates is an opportunity to drive such improvement. If this strand of work is rooted in a comprehensive review of processes and performance issues for IPC, informed by the findings and recommendations made through the Oversight Board and other review processes, this could prove a powerful vehicle for delivering a change in approach to improvement.

Remaining Work

84. As already stated, this Interim Report does not cover all aspects of the Oversight Board’s review of IPC. Several critical aspects are still being examined and will feature in the Final Report, including:

- Responsiveness: how responsive were IPC functions in identifying and taking appropriate action with regards to the children and young people in these infection incidents – not just in terms of addressing the incidents themselves and learning quickly from the experience, but also the efforts to understand the source of infections and take appropriate preventative measures;
- Responsibilities and structures: the roles, resourcing and organisation of the IPC Team in the QEUH, as well as relations with other parts/functions of NHS GGC;
- Culture: how well did the IPC Team work internally and with other key staff, with a particular focus on the working environment and how this might have affected NHS GGC's overall effectiveness in IPC; and
- Leadership: the strength of the current structure of responsibilities for the IPC Team in NHS GGC, and whether those divisions of responsibilities are best suited in these circumstances.

85. While recommendations on the aspects of IPC discussed here are made at the end of this Interim Report, the full conclusions of the Oversight Board on IPC will be made in the Final Report.

86.

Governance and Risk Management

87. The second set of escalation issues which the Oversight Board is examining is Clinical Governance. Its importance has been captured in the Blueprint for Good Governance for NHS Scotland[11], which sets out key principles Health Boards should embody, including the ability to:

- identify current and future corporate, clinical, legislative, financial and reputational risks; and
- oversee an effective risk management system that assesses level of risk, identifies mitigation and provides assurance that risk is being effectively treated, tolerated or eliminated.

This is supplemented by the descriptions of good clinical governance and the approach all Health Boards should take towards quality planning and management in key documents by HIS[12].

88. With respect to IPC, that covers a range of important areas, such as the way in which infection incidents and corresponding actions are escalated, scrutinised, endorsed and monitored by the clinical governance structure within a Health Board. It also includes how IPC and associated risks are identified, reviewed and overseen by relevant Committees (as well as the Board itself). Consequently, the Oversight Board is reviewing in detail:

- how infection incidents from 2015 onwards were identified and escalated through the governance structures of NHS GGC;
- how risk management was used and adopted accordingly,
- how well the relevant Committees and groups provided direction, monitoring, scrutiny and assurance about the handling of individual incidents, the way in which staff responded, how people were kept informed about what was happening, any weaknesses identified in the building/environment as a result, and the actions taken to address those weaknesses and prevent further problems in future; and
- the overall leadership shown in acting effectively in response and with foresight in dealing with the complicated challenges highlighted by the building.

Progress Update

89. Assessment of these issues has also been led by the IPC and Governance (IPCG) Subgroup for the Oversight Board. This includes the following specially-commissioned work:

- a ‘timeline’ of infections and the Health Board’s responses between 2015 and 2019;

[11] https://www.sehd.scot.nhs.uk/dl/DL(2019)02.pdf.
[12] http://www.healthcareimprovementscotland.org/his/idoc.ashx?docid=e4e2a8ce-342e-4e5c-b998-1f81859b282f&version=-1.

- detailed analysis of the minutes and papers of the IMTs, various groups and Committees about how the issues were reported, escalated, actioned and reviewed within the Clinical Governance structure; and
- a specific peer review of IPC governance and the recent changes introduced within the Health Board by the IPCG Subgroup.

90. All of this work is still to be finalised so the Oversight Board will set out its findings and recommendations on Clinical Governance in the Final Report.

Technical Review

91. Part of the Oversight Board's role has been to provide assurance not just on practice, but – as far as possible – the relevant physical environment of the QEUH and the Health Board's approach to inspecting and maintaining that environment. The Technical Issues Subgroup was established to provide advice on key aspects of this, including:

- assurance that the relevant environments at the QEUH and the RHC are, and continue to be, safe;
- progress on the refurbishment and reopening of Wards 2A and 2B in the RHC, following its closure in September 2018, so that children and young people can return to the Unit specially designed for their needs;
- how appropriate action plans have been developed and taken forward to address any technical issues highlighted by competent authorities such as the Health and Safety Executive, HPS and HFS; and
- lessons learned that could be shared more widely across NHS Scotland.

Progress Update

92. The work of the Subgroup is continuing and will be set out in full in the Final Report. Given its technical focus, there have been difficulties arising from the Covid-19 pandemic in progressing this work as quickly as desired. Nevertheless, working closely with NHS GGC, the Subgroup is currently undertaking reviews of:

- NHS GGC's water safety policy, with specific attention given to its water testing regime and how testing results are being used as part of IPC and the key water and ventilation infrastructure in light of the infections across the hospital site; and
- NHS GGC plans to review the impact of the chemical dosing system introduced from late 2018 to address water system contamination, especially any potential implications for the existing water infrastructure.

Refurbishment of Wards 2A and 2B in the RHC

93. The Subgroup has also reviewed progress on refurbishing Wards 2A and 2B in the RHC. Originally, when the children and young people were first de-canted from the wards, it was hoped that the work would be relatively limited. However, as further investigation was conducted on the state of the wards, it was clear that significant additional work would be required to redress shortcomings in the original building work, particularly with respect to ventilation issues.

94. The completion date for Wards 2A and 2B has now shifted to May 2021. The principal reason for the delay has been Covid-19, which has had an impact in an number of areas, including the procurement of relevant plant and equipment, essential staff being furloughed, social distancing being enforced (which has affected timescales) and the site needing to be shut down on one occasion following a positive Covid-19 test result. In addition to these issues, as it has been upgrading the ward, NHS GGC has identified

additional problems with mould, fire stopping and insulation in external walls which have all needed to be rectified and that has added time to the programme of work.

Communication and Engagement

95. The Oversight Board was established against a background of increasing dissatisfaction and distress among families of the children and young people in the paediatric haemato-oncology service, reacting to how NHS GGC had been communicating the continuing issues around infection in the hospital. In November 2019, the Cabinet Secretary for Health and Sport met with several families, which led to a set of 71 issues and questions about the hospital and the infections being posed to NHS GGC. The issues on which families felt frustrated in getting information from the Health Board included (but were not limited to):

- assurances on the current safety of the water system and the wider clinical environment for the children and young people;
- progress with key remedial work on different wards, including 2A and 2B in the RHC from which the Schiehallion Unit had been de-canted in 2018;
- issues relating to the current location of the children and young people in the haemato-oncology services in Ward 6A in the QEUH;
- the adequacy of IPC measures in place;
- conflicting messages in the communications given to patients and families as the infection incidents had progressed; and
- a perceived lack of compliance with the organisational duty of candour.

Responses to those questions were provided to families and subsequently posted by NHS GGC on its website, and the issues raised helped to set the remit of this Oversight Board.

96. Discontent with NHS GGC's communication was also evident in the survey conducted by Professor Craig White of this group of families in December 2019. Twenty responses were received, with the majority of respondents saying they were not satisfied with the level of communication about the ongoing issues by the Health Board, with clear dissatisfaction expressed about NHS GGC's performance in this regard. The issues experienced by families were many and varied: some were individual and personal matters relating to their own children, while others reflected a more common set of concerns about how the Health Board was engaging with them.

97. Supporting patients and families in the midst of a prolonged crisis would have been challenging to any Health Board. It was made particularly complex for NHS GGC by the difficulties in providing the children, young people and families with certainty and clarity about what has happening, as will be seen below. Nevertheless, the experience of some patients and families pointed to problems of the Health Board in its approach to communication, and the view by some that the Health Board was failing to exhibit the essential person-centred principles to communication that are the cornerstone of NHS Scotland.

98. The strength of feeling among several families highlighted the importance of engaging with families throughout the Oversight Board's work. A dedicated Communication and Engagement Subgroup was established, chaired by Professor White and with

membership including communication experts from other Health Boards as well as representatives of the families themselves. It provided a forum for direct exchange of views and discussions between the Health Board and family representatives.

99. The Oversight Board set two key success indicators for NHS GGC in its approach to reviewing communication and engagement. Patients and families within the paediatric haemato-oncology service should receive relevant information and are engaged with – and are treated with respect to their rights to information and participation – in a culture that reflects the values of NHS Scotland in full. That should be seen in the following.

- *Families and children and young people within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of the NHS Scotland in full.*
- *Families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHS Scotland in full.*

100. In its work, the Subgroup concluded that evidence of this kind of success should be seen through the following:

- priority is placed on communication and information provided to patients and families with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);
- the Health Board ensures there is an appropriate Communication and Engagement Plan with a person-centred approach, including a clear Executive Lead for implementing and monitoring; and
- a review is conducted of key materials, policies and procedures in NHS GGC with respect to the organisational duty of candour and Significant Adverse Event Reviews, and identification of any national learning/lessons learnt.

101. Not all of the work carried out for the Oversight Board through the Subgroup is set out in the Interim Report. NHS GGC's approach to its organisational duty of candour and how it addressed Significant Adverse Event Reviews are key elements of how a Health Board should engage with patients and families when death or harm occurs within a hospital setting. They are processes that are governed by legal, regulatory and guidance frameworks, and the Oversight Board's findings here will be set out in the Final Report.

102. The Interim Report focuses on the extent to which communication and engagement by NHS GGC has reflected consistent delivery of the overarching principles outlined above, rooted in the NHS Scotland approach to person-centred care. These issues are considered under the following headings:

- the strategic approach to communication in NHS GGC;
- application of this approach in IPC, and the issues experienced by patients and families through this period; and
- scope for improvement.

Strategic Approach to Communication

103. The principles of good communication in healthcare settings have been clearly expressed nationally. The Director-General of Health and Social Care in the Scottish Government's and Chief Executive of NHS Scotland's letter of 22 February 2019[13] stressed the importance of appropriate communication:

> *"Our learning so far from the degree of public interest in these issues makes very clear that communication is always better done directly with those most closely affected first. We should, as far as possible, be alerting staff, patients and families before making any public statements and the service and Scottish Government should work closely together in our communications with the public."*

104. NHS GGC's own stated objectives for person-centred care are set out in it 2019-23 Healthcare Quality Strategy[14]. This represents a level of aspiration – and a means of measuring how well NHS GGC currently operates – that the Oversight Board endorses. Responding to what patients and families wanted, the Strategy aims for a high-quality service that:

- takes time with patients and listens to them;
- takes care of people, looks after them and makes sure they get the right treatment;
- communicates well with patients by explaining all they need to know and involving them in decision making;
- is knowledgeable, safe and trustworthy;
- is efficient;
- is caring, compassionate and shows empathy;
- has friendly, kind, competent and professional staff; and
- communicates with the people who matter to them regarding their progress and condition.

105. The Health Board has recognised the kind of communication and engagement that should be expected for these patients and families in its description of 'Person-Centred Care' with the following series of commitments in that document.

- *We will enable people to share their personal preferences, needs and wishes about their care and treatment and include these in their care plan, care delivery and in our interactions with them.*
- *We will involve the people who matter to them in their care in a way that they wish and that meets the requirements of the Carer's Act (2018).*
- *We will develop further the person centred approaches to visiting throughout NHS GGC.*

[13] https://www.sicsag.scot.nhs.uk/hai/_docs/HCAI-DL-2019-23-Dec-2019.pdf.
[14] https://www.nhsggc.org.uk/media/253754/190219-the-pursuit-of-healthcare-excellence-paper_low-res.pdf.

- *We will make sure people experience care, which is coordinated and that they receive information in a clear, accurate and understandable format, which helps support them to make informed decisions about their care and treatment.*
- *We will give people the opportunity to be involved and/or be present in decisions about their care and treatment and include the people who they want to be involved in accordance with their expressed wishes and preferences.*
- *We will provide training and education, to enable staff to treat people with kindness and compassion, whilst respecting their individuality, dignity and privacy.*
- *We will inform people about how to provide their feedback, comments and concerns about their care and treatment. We will review our approach to collecting and managing feedback to make sure it is fit for purpose.*
- *We will make sure there is a collaborative and consultative approach in place to enable staff to actively listen, learn, reflect and act on all care experience feedback received and to ensure continual improvement in the quality of care delivered and the professional development of all staff.*
- *We will continue to identify and build opportunities for volunteers to help improve the health and wellbeing of patients, families and carers.*
- *We will engage with people, communities and the population we serve to deliver high quality services to meet their needs.*

106. The centrality of these communication principles is reflected in other NHS GGC strategies. In particular, the Health Board developed a dedicated communication strategy for infection issues: *Healthcare Associated Infection Communications Strategy*[15], published in 2015 (and due for review in 2019). The Strategy stressed "*the importance of a culture of openness, transparency and candour*". It acknowledged the need to learn from incidents such as the Mid Staffordshire NHS Foundation Trust Public Inquiry as well as the impact of the Vale of Leven Hospital outbreak of *C. difficile* and the recommendations from Lord Maclean's Inquiry.

107. The Strategy set out the principles of communicating infection diagnosis and risks, and included key actions to be taken forward in individual cases such as (but not limited to) the following:

- every patient should be informed of the risk of infection and the actions being taken to prevent healthcare associated infection;
- if a patient is diagnosed with an infection, the diagnosis should be discussed with the patient by one of the members of the clinical team if possible; and
- the Health Board should ensure that if a patient dies with an infection which is either the primary cause of death or a contributing factor, families are provided with a clear explanation of the role played by the infection.

[15] https://www.nhsggc.org.uk/media/243043/hai-communication-strategy-july-2015.pdf.

108. The Strategy presented a clear baseline of principles against which the actions with respect to the QEUH infection incidents can be considered. As noted, the Strategy is several years old and is due to be updated; in light of recent experiences with the QEUH, and the recommendations set out here (and in the Independent Review), there is a strong impetus for a new, revised version of the Strategy to be produced and issued.

Communication in the Context of Infection Prevention and Control

109. While a statement of principles and standards is vital, what matters most is how strategic aspiration is translated into action. Good practice was clearly evident. When reviewing how the Health Board responded to the unfolding circumstances of infections, the Oversight Board noted evidence of improvement already at work within the Health Board. It is important to highlight this, not least as practice that could support national learning.

110. Throughout the incidents, there was generally a recognition (not least by the children, young people and families themselves) of good communication at the point of care. At ward level, communication was often effective and sensitive, displaying the Health Board's person-centred values in how it responded to individual patients' and families' circumstances. Direct communication by the clinical and medical staff have been highly regarded by the children, young people and families throughout, not least when it related to the individual care of patients.

111. Communication to patients and families individually at the point of care was undertaken with compassion, care and support by the relevant staff, especially in the Schiehallion Unit. Ward staff were often the key means by which major, and often unsettling news was conveyed, such as the decision to de-cant Wards 2A and 2B in September 2018 (as discussed more fully below). As noted by one respondent in the December 2019 survey of families:

> *"Clinical staff provide timely and relevant information on… treatment. Someone is always available when we have questions. When I was stressed about a delay to surgery, nursing staff picked up on that and arranged for consultant to contact me."*

Despite the pressures to provide regular communication on the infections and the impact that they had on day-to-day operations, the focus on providing a high-quality service was never lost in the engagement with the children, young people and families. The Oversight Board commends that commitment by staff on the ward to keeping patients and families directly informed.

112. There was also evidence that the Health Board was capable of learning to address the challenges of maintaining complex and often prolonged communication with patients and families in difficult circumstances. A good example of this was the development of the 'closed' Facebook page for patients and families, as described in more detail in the box below. This Facebook page has been a critical means of alerting patients and families to key developments and issues as well as enabling them to raise important issues with the Health Board – indeed, the value of the mechanism has extended beyond the immediate infection issues for the patients and families, and developed into a means of supporting the group of families, children and young people for other issues. For example, it has become an important means of identifying and acting on issues affecting this group of patients during the Covid-

19 pandemic. Although the key to its value is ultimately the responsiveness of the Health Board to the issues raised on the page, it was an innovative and useful tool that highlights the capacity of the Health Board to improve.

'Closed' Facebook page for patients and families

The decision to develop a customised Facebook page for the Schiehallion Unit patients and families emerged from the experience of using the existing social media services. In the first few months of 2019, public and media attention on the problems of the QEUH was particularly acute, increasing the need for families to find a way to express and discuss their concerns, seek and receive information, and engage with the Health Board on the continuing implications of the infections for their children.

In January, it was agreed that a 'closed' Facebook page would be established for the benefit of patients and families – a decision that was endorsed by the Board itself, commendably demonstrating the importance of improving patients' and families' communication within NHS GGC. A form of 'gate-keeping' of the page's membership would be provided by NHS GGC itself to protect the privacy of the discussions, but the forum was allowed open and full access to members.

The Facebook Group was launched in September 2018 for patients and families associated with their paediatric haemato-oncology service. Initially, the number of members was approximately 50, but over time, membership increased significantly; currently around 180 members are listed. It has the potential to become a central mechanism for parents to engage collectively with NHS GGC clinical leaders within the ward and the Board's staff who support corporate communication and engagement activity. Executive-level responsibility for engaging with patients and families has now been placed with the Health Board's Nursing Director – the first time a Board member was explicitly and visibly put forward in such a way.

Since escalation, families have expressed positive feedback about how the Facebook page keeps them informed of statements from Scottish Government Ministers as well as the work of other key reviews (and indeed, the work of the Oversight Board). There are some encouraging recent examples of this being used effectively to support dialogue with patients and families who have expressed concerns about (for example) the quality of the food in Ward 6A, including engagement on an event involving parents who wish to work with staff on improvement planning. While discussions on the pages are sometimes critical of NHS GGC, it represents a willingness by NHS GGC to support constructive debate and challenge for those most affected by the continuing problems and decisions taken by the Health Board, though it must continue to be used pro-actively and there remains work to ensure that this is done consistently.

113. NHS GGC has also undertaken work to ensure that individual children, young people and families have relevant communication/information specific to their needs and relevant of their histories. Not all patients and families have wanted the same level of engagement and information with the Health Board, and it was important to recognise their different circumstances and preferences. Given the sensitivities arising from the experience of many of these children and young people, it was also important that Health Board communications did not appear unnecessarily generic, but recognised a history of communication with particular families, and indeed, reflected the often difficult circumstances of their children that lay behind individual communications.

114. This led to the development of a specially-commissioned database to facilitate improved engagement with concerned patients and families and how they preferred to be contacted; the box below describes this in more detail. This as an important development that would be of value across NHS Scotland more widely. It has enabled communications to be formulated in a way that respects communication and engagement preferences, and clearly embeds a person-centred approach.

Database of contacts and communication preferences for patients and families

A database of contacts with the Scottish Government and NHS GGC was commissioned following the escalation of NHS GGC to Stage 4 in the NHS Scotland Performance Framework in November 2019. Based on the existing communication with over 400 families, the database compiles key information on preferences. It uses NHS National Office 365 SharePoint to capture the history of communication with particular patients and families. It has strict permissions settings in place and is sharable with colleagues in NHS GGC and Scottish Government links. The database supports improved oversight, makes it manageable to incorporate enhancements and changing requirements, and to add users. Its protocols can potentially be adapted to support future oversight requirements if/when Scottish Government/NHS Scotland coordination and comprehensive overview is required.

There is scope for improving the value of the database further. This tool could be supplemented by enhancing the existing family 'induction' packs with clear information on where patients and families could go for information about continuing issues such as the infection incidents. It also has applicability that goes beyond the paediatric haemato-oncology service, but could be deployed usefully whenever there is prolonged communication between the Health Board and a particular patient/family group.

115. Nevertheless, where communication and engagement went beyond the ward level – particularly with respect to 'corporate' communications on behalf of NHS GGC as a whole – there were a number of deficiencies. Such corporate communication has an essential role, as ward staff were not always the most appropriate channels for information, particularly when it involved a wider communication effort, targeted not just at the children, young people and families but staff and the wider public and media. In this context, the approach to communication and engagement by the Health Board did not consistently match the person-centred principles of its strategies.

116. This can be highlighted when considering how communication operated at specific points over the period. Key milestones in the timeline of infections spotlight how the Health Board acted:

- the decision to de-cant Wards 2A and 2B in the RHC in 2018;
- the introduction of a comprehensive water dosing system in 2018;
- the series of new infections in QEUH wards in 2019; and
- recent issues in the wake of the announcement of legal action.

All provided critical points when communication with patients and families was particularly sensitive, and are worth examining in detail.

<u>Decision to De-cant Wards 2A and 2B in 2018</u>

117. The decision to de-cant the children and young people from Wards 2A and 2B in the RHC to Wards 6A and 4B in the QEUH in September 2018 was one of the most visible and public milestones in the development of the infection incidents. Closing the wards would inevitably be regarded as an admission of the seriousness of the series of infection issues and open up the Health Board to potential accusations that it was not in full control of the situation. Consequently, good handling was vital.

118. The decision came on the back of a resurgence of infections within the RHC wards, leading to the restoration of the IMT after it had been stood down twice since March of that year. It was made relatively quickly, reflecting an urgency around the need to investigate the source of infections in the wards more thoroughly and mounting concerns by staff on the wards and families around the safety of the environment. It was also made at a point when concern, investigation and speculation had resulted in substantial disruption in the care of this group of children and young people. There was a significant physical/logistical challenge in ensuring that the new wards were altered to provide appropriate care for these vulnerable children and young people and manage the movement of patients on 26 September, but there was an equally important challenge in communicating the key information and the rationale to patients and families, addressing their questions while providing reassurance around the continuity and security of care.

119. The news was put out in a number ways on 18 September and the days that followed. For those on the wards, much of his was done through leafletting. A hand-out, dated 18 September, set out the details of the de-cant. It highlighted the need for further invasive exploratory work on the source of infections, involving the drains as the primary reason for moving the children and young people, and emphasised the priority of their safety and care. The statement – which formed the basis of a media release the same day – did not offer details of where most children and young people in the Schiehallion Unit were moving to in the adult hospital (arguably a singular omission, given that the location had already been discussed in planning with senior management). On its own, the lack of detail on the nature and duration of the move would not have given sufficient reassurance to the children, young people and families. Nevertheless, the communication work – particularly through the direct support of those *in situ* on the wards – seems to have been effective in managing a sudden and sensitive change of circumstances for the patients and families. The challenge for the Health Board was not made easier by false information carried in news outlets that the de-cant had already taken place, resulting in distress in some families on which swift and targeted action was taken by senior managers within NHS GGC.

120. The de-cant was originally envisaged as a short-term move, and presented as such to patients and families. As the investigation of Wards 2A and 2B revealed a succession of environmental deficiencies, going back to the original construction of the wards, it became clear in the succeeding months that it was unlikely that the children and young people would be restored to the original wards soon, and the stay in Wards 6A and 4B would be prolonged. However, the communication of this to patients and families appeared to be faltering. No formal updates on the work on Wards 2A and 2B seemed to have been made to the patients and families through October and November 2018, and it was evident that staff were reluctant to discuss the changing work timetable until a fuller picture of the problems in the wards was known (in particular, staff were waiting on key external reports on ventilation before providing an update). The absence of corporate updates in this period would have not been reassuring to those already experiencing considerable distress and uncertainty. The

decision seemed to have been taken that it was better to 'have something to say', but this lack of communication was not reflective of the Board's strategic commitment to person-centredness. It compromised the confidence and trust that families with ongoing concerns and unanswered questions had in the Health Board.

121. When an update was forthcoming in December, it downplayed the emerging environmental issues emerging from the investigations of the wards. Briefing to patients and families on 6 December 2018 cast the further delays as an 'opportunity' to upgrade the ventilation. This suggested a lack of transparency about the emerging scale of issues encountered on Wards 2A and 2B. While communications should be mindful of causing unnecessary alarm, the approach seems to have contributed to a deepening suspicion among some families that the Health Board was 'covering up' issues relating to the hospital building. While there is no evidence of deliberate concealment of any such information, throughout 2019, the formal updates to patients and families about progress with Wards 2A and 2B seemed intermittent and not transparent about either the real difficulties experienced with the programme of work or the delay to a return of the children and young people to the RHC. It was known in January 2019 that any prospective return to Wards 2A and 2B was unlikely to occur before the end of that year, but this does not appear to have been fully and openly communicated to patients and families likely to be affected by these decisions.

122. This apparent omission might be indicative of the highly reactive environment that the Health Board faced, not least in the early part of 2019, as there were a number of immediate communication issues on which action needed to be taken. But it reinforced an impression that NHS GGC was not forthcoming about key information regarding the situation with the building, leading to an avoidable increase in distress and subsequent deterioration in the relationship between some families and the Health Board.

Introduction of the Water Dosing System in 2018 and 2019

123. The installation of a site-wide, water dosing system was a decisive step taken by the Health Board to address what seemed to be mounting environmental risks in 2018. The decision was not taken lightly, but followed extensive options appraisal by the specially-created Technical Water Group and careful planning to manage its introduction with minimum disruption to staff, children, young people and families. The option was raised quickly by the newly-established Group in the early stages of the 'water incident' in the first half of 2018; by the end of the year, the implementation of dosing was completed for the QEUH and extended to the RHC through 2019. It represented the most emphatic action by the Health Board to address the risks of widespread water contamination, a significant achievement in terms of the speed and scale of response.

124. From a communication perspective, the use of comprehensive chlorine dioxide dosing has several important dimensions. It demonstrated the responsiveness of the Health Board and its willingness to 'do what was necessary' to mitigate risks to patient safety and provide assurance to patients, families and the wider public about hospital safety. At the same time, it needed to be explained carefully to ameliorate any concerns (not least among patients and families) that might have arisen about having to treat the water with 'chemicals' and the impact that could have on patient health. Moreover, there was a risk it could be framed by some as a Health Board admission that there was widespread water contamination in the hospital and the impossibility of removing the source of the contamination without such dosing action. There were communication implications that went beyond the paediatric

haemato-oncology patient group, as the water dosing would affect a wider number of patients. As a result, careful handling of information and messages with patients and families was critical.

125. Dosing for the adult hospital was agreed in early November 2018, and a communication was to be issued as soon as the timeline for the work was finalised. It was not clear how this was widely communicated, either in the lead up to the point at which the adult hospital dosing system was put in place (28 November) or in the period afterwards through information presented to patients and families. In mid-January 2019, apparently following complaints made by some families directly to the Scottish Government about the more general quality of information being provided by the Health Board, briefing was provided about the dosing. However, the written information was opaque:

> *"It is also important to note that the additional measures to ensure water quality have been put in place for the whole site (QEUH/RHC) and these have been successful. Our rigorous water quality testing is demonstrating good results alongside the ongoing use of water filtration devices."*

A fuller description of the chemical dosing system and its implications did not appear to be forthcoming in the following months, though references were made in subsequent briefings to patients and families. It further highlights what seems to be a different approach between what was communicated on the ward – where there would have been opportunities for direct questions from those patients and families present – and what was communicated through corporate channels.

<u>New Infection Incidents in Wards 6A and 4B in 2019</u>

126. The de-canting of the children and young people into Wards 6A and 4B should have been seen as an end to a period of severe anxiety about environmental risks. Consequently, the appearance of new infection incidents in the QEUH wards in 2019 caused renewed, if not higher levels of distress and raised further questions about the capacity of the Health Board to manage IPC. The new series of infections from June presented the Health Board with new communication challenges. At this point, the issues had features that were not present before. It carried a strong risk of suggesting that whatever action had been taken before had 'not worked' and that NHS GGC was not 'in control of the situation'. This was compounded by the difficulties that the IMT in the second half of 2019 faced in identifying the source of the new infections. As with the 2018 'water incident', strong IPC measures were required such as the closure of Ward 6A to new patients for a period, which led to disruption for the children and young people. The potential for undermining trust in NHS GGC was acute.

127. During that period, the Health Board endeavoured to keep patients and families updated on what was going on at different points. Verbal and written briefings continued to be provided after each IMT meeting, and a new dedicated Facebook group/page was established. While there was significant (and arguably inevitable) repetition of information across the different updates, the fact that they were being made was evidence of the Health Board recognising the importance of maintaining the flow of information to patients and families.

128. However, there seemed little open recognition of potentially deeper issues with regards to the environment. By this stage, the notion of widespread water contamination was becoming increasingly accepted – while the pathways and sources of infection eluded

detection, the idea that the water system may have been contaminated at some stage in the construction/commissioning of the hospital was present in the HPS report on Wards 2A/2B and the accompany HFS report. The briefings to patients and families did not acknowledge these issues, but instead emphasised that "*we have undertaken extensive testing of the ward environment and at this stage no link has been detected between the infections and the ward environment or our infection control practices*" (as set out in an October 2019 briefing, but presented in similar phrasing in other briefings at that time). Patients and families were, of course, increasingly aware of the wider issues relating to the building, which meant that through this period there may have been a widening divergence between what several families understood from other sources and what they were being told by the Health Board.

129. Statements by the Health Board, of course, must be factually accurate. There is a risk in conveying perceived risks about the environment without fully understanding what is happening. Nevertheless, as more infections occurred in 2019, uncertainty around the environment would not go away, and communication efforts should have adapted to recognise and respond to that uncertainty. The lack of reference to these wider risks seems to have exacerbated a perception that the Health Board was increasingly focused on 'managing' rather than providing information. It reflected what appeared to be a greater priority on reputation management than regular, pro-active and supportive communication more explicitly informed by the perspective of patients and families. This approach to communication – one that provided messages that were supportive of the organisation but did not consistently respond to individual patient concerns – seemed to have diminishing returns with an (understandably) increasingly vocal and expanding group of families that were unhappy about the lack of transparency in what was going on. By not openly acknowledging more readily what was *not* known about the infections, the Health Board created the impression that it was simply hiding something that was alleged to be known about the building. This potential trap is perhaps most tellingly demonstrated in the following more recent milestone.

Recent Issues Following the Announcement of Legal Action by NHS GGC

130. Since the Oversight Board was established, NHS GGC has announced that it was launching a legal case against the QEUH builders, Multiplex. As a result, the Health Board has become notably more sensitive to communication that could have a bearing on the conduct of the legal case, and as a result, has become increasingly reluctant to comment or discuss aspects of the infection incidents and the related issues, citing the risks of compromising the forthcoming legal case. This featured recently in its responses to the Independent Review's report on the commissioning, design, construction and handover of the hospital complex and a BBC Scotland Disclosure documentary on the QEUH (which aired in June 2020), when the Health Board was notably limited in its response to the issues raised. This has exacerbated a sense among several families that the Health Board had continued not to pursue a policy of transparency and sensitivity to the affected children, young people and families.

131. The Oversight Board appreciates the legal sensitivities facing the Health Board, particularly where it is likely to be made on the back of internal legal advice, but considers that continuing reluctance to be more open on many of these issues is exacerbating rather than resolving the fundamental concerns on communication and engagement that gave rise to escalation to Stage 4. This is particularly relevant given that the timescales for the legal action are not clear at this point, but could last for a prolonged period. A better balance about

engaging on the challenges and history of addressing the problems of the QEUH is needed if there is to be restoration and trust in the Board's commitment to, and delivery of pro-active, transparent, compassionate and supportive communication and engagement where patients and families express concerns or ask questions. This should be irrespective of the number of families involved or any perceptions regarding their 'representativeness' with respect to the wider group of affected families.

Observations

132. All of the incidents described above show strong direct communications, but problems with corporate communication to the wider group of patients, families and ultimately, the public. There seems to be several recurring themes.

133. First, there was a lack of timely information on what was known about the infection issues and what actions were being taken as a result. Points raised by some families included:

- a widespread feeling that the Health Board was slow to respond to specific queries put to them about their children's care (for example, concerns in respect of the time taken to respond to the issues later reflected in the summary of 71 questions and issues that were put to the Cabinet Secretary for Health and Sport by family representatives in late 2019), and that communication with patients and families could sometimes 'lag' official press releases on media stories;
- suggestions that patients and families were hearing about key information through the media and press releases by the Health Board, rather than directly, adding to an impression of too often being 'kept in the dark'; and
- in a few cases, allegations that the Health Board was not answering questions "*properly or truthfully*", as one of the respondents to the family survey noted.

134. Such comments have been persistent across the period. For example, suggestions that there was a lack of transparency by the Health Board were made by some families at the start of the 'water incident' in March 2018. They have continued through to more recent discussions and the reaction of families on the Facebook page to the BBC Disclosure Scotland documentary in June this year. Across the period, communication did not always demonstrate to these families a clear, person-centred tone in addressing such sensitive issues. The work by Professor Craig White as 'family liaison' to support the way NHS GGC was drafting its public messages from late 2019 also highlights the need of the Health Board to develop more person-centred language in how it reacts to critical media stories.

135. Several families, particularly those with prolonged and continuing engagement with the Health Board because of the care and circumstances of their children, felt that the Board was often reluctant to provide direct answers to their questions and information about the hospital. This reluctance was fed by a sense of sluggish responses to questions posed, a strong impression of information being partial or misleading and a belief that the Health Board would not admit any mistakes that might have been made regarding the environment of the building or the care of their children. These views were not shared by the Health Board, and it was occasionally suggested that the responses reflected a minority of families that were explicitly expressing their views. Nevertheless, it was clear that the views of several families became more entrenched over the period, and that any communication and engagement efforts by NHS GGC to address distrust and lack of confidence in the Health Board did not fundamentally shift this sense of distrust. The obligations of the Health Board

to respond openly, compassionately and supportively to any patient or family who raises concerns has not been consistently evident in the thinking, decision-making or actions of senior staff.

Scope for Improvement

136. While the Health Board has strived to learn from the unique situation it faced, there remains a continuing need for improvement in how communication, engagement and information provision takes place. Part of this requires a fuller understanding of the challenges facing the Health Board with respect to communication, not least in terms of national learning to be gained from how to respond to infection outbreaks.

137. One key challenge was how to communicate a complex set of issues where uncertainty would not go away. This uncertainty had different dimensions to it. The exact source of infections was not clear throughout the period –- this proved a complex problem for the Health Board through 2018, where the picture of what was taking place developed incrementally. Knowing what and how to communicate with children, young people and families in this situation was not relatively straightforward. This was complicated with the difficulties of engaging with patients and families who were no longer in regular contact with the service. In particular, the timing of when to update patients and families was often hard to determine, not least in an environment of significant media scrutiny. Providing timely, full information to families was not always easy. Social media was a particularly complicating factor, as it could convey stories more quickly than the Health Board was accustomed to responding act as an amplifier – if not in some cases, a distorter – of some of the concerns being expressed. At the same time, the Health Board was seen as slow to take advantage of social media as a means of communicating with patients and families, and indeed, the wider public, about key developments, or addressing any misconceptions being disseminated.

138. Nevertheless, while these challenges made communication decisions more difficult to take forward, there are several areas where NHS GGC must take action to ensure the delivery of necessary improvements:

- the communication responsibilities of IMTs;
- coordination between different teams/services in communication;
- communication with staff;
- visibility and approach of senior management in communication; and
- the role of external bodies in supporting communication.

<u>Incident Management Team Responsibilities</u>

139. In line with national practice, the responsibility for communication decisions is typically lodged with IMTs – what to communicate, when and through what media – with communication advisors providing support and IMT Chairs with a key role in taking decisions. Throughout 2018 and 2019 in particular, IMTs were clearly active in response to communicating the infection incidents.

140. IMTs are often necessarily focused on specific outbreaks. While understanding a wider context of infection can be critical for determining the source and mitigation, the idea

of a *communication* context to outbreaks seems less well appreciated. For the children, young people and families affected, a series of infections may appear part of a single continuum of events, potentially marked by escalating anxiety and disruption. This perception of a continuing 'crisis' did not seem to inform the approach to communication across the period, where actions were regarded typically in terms of addressing short-term issues. The IMT process, while useful for these more incident-based situations, was potentially less effective for a prolonged scenario when a number of incidents could be linked together by patients and families (and as became the case in 2019, in the eyes of the media, politicians and the public).

141. A better process should be identified to allow for infection incidents to be more explicitly considered within that broader context. This should take full account of previous communications, consistency in messages where appropriate and the recognition that the audiences of these communications have changing expectations of what they want to know from the Health Board as the 'crisis' develops (particularly if initial questions about the source of infections cannot be quickly addressed). The learning for NHS GGC here would have a clear national dimension as well. Such a process may involve shifting some communication responsibilities away from the individual IMTs when it becomes clear that the incidents are being seen in a larger context. This would need to have clearly defined triggers, roles and responsibilities. This was particularly evident in relation to the responsibilities for developing and issuing press releases, as it was not clear to the Oversight Board where full responsibility was being exercised and the extent to which this was led by IMTs in practice.

Coordination of Communications

142. Infection issues can draw in the work of several services within the Health Board, including clinical staff, the IPC Team, Facilities and Estates, and senior managers. Clear coordination and a common approach to information, messages and the culture of communication is essential.

143. NHS GGC was not consistently integrated in its communication in this context. Key messages, especially when delivered directly on wards, would have often benefited from a more systematically joined-up approach, particularly between the IPC Team and facilities/environment personnel. Some families had reported that while ward-level communication was delivered compassionately and usually at the right time, that communication would have been more effectively delivered if they were made with the visible involvement of other staff who have a clear link to what was being communicated.

144. This was particularly highlighted for issues relating to changes in the estate and the physical environment as a result of the incidents – whether local changes such as the use of water filters on taps in rooms or wider changes, such as the de-canting of the whole of Wards 2A and 2B. Assurance would have been more strongly communicated to patients and families had these messages been more regularly undertaken jointly by clinical and Facilities and Estates staff.

145. Overall, the Health Board's corporate messaging needed to be more joined up in terms of recognising the range of activity that was taking place at any one time. The issuing of single-narrative corporate briefing points to NHS GGC's recognition of the importance of a common message. But as these briefings sometimes needed to be supplemented with questions directly posed by the families, it resulted in ward staff sometimes appearing not

fully informed enough to address the concerns presented to them. This was particularly true in 2019 with the new series of infections in the QEUH wards, when many of the families' questions related to more technical, environmental subjects that were best addressed by Facilities and Estates staff. As a result, the consistency of the information and messages across different levels of the organisation was not evident across the period, adding to the frustration experienced by some families and putting more pressure on ward staff.

Communications with Staff

146. This chapter has focused on communication and engagement with patients, families and the public, but there was an equally important need to provide regular information and reassurance to staff as well. This was important because of the duty of care of the Health Board to its staff, recognising their concerns about working in a potentially 'unsafe' environment as well as their natural compassion for their patients. It was also critical given the vital role that staff – especially those on the wards – played in providing information to patients and families. Communication with staff was another aspect of wider engagement with the public.

147. Staff concerns were evident throughout this period. While the concerns about the risks of the building tended to be expressed by individuals before 2018, from the 'water incident' onwards it became a continuing source of anxiety for groups of staff. For example, in September 2018 (before the de-canting), staff in Wards 2A and 2B were reported to have been visibly upset and anxious at a staff information event, and some approached their union for advice about the safety of their patients remaining within the ward. Specific decisions could raise concerns, such as the blanket use of anti-fungal prophylaxis as part of the IPC measures – in December 2018, some medics expressed concerns about the prescription of prophylaxis, as several children had experienced severe reactions. Moreover, when the *Cryptococcus neoformans* infection was drawing intense media scrutiny in early 2019, staff were reporting their own respiratory problems that they felt might be linked to ventilation /infection issues.

148. The Health Board responded actively to these concerns: there were regular briefing updates to staff (often weekly during the most intense periods), face-to-face meetings with senior hospital managers and active engagement by the IMTs through the Lead Infection Control Doctor. The commitment to keep staff up-to-date and supported through this period was evident, and there is no suggestion that the Health Board was not forthcoming to its staff about what was happening.

149. Nevertheless, while the regularity of such communications may have allayed anxieties, they could not remove them, for the same reason that some families remained dissatisfied with Health Board communication efforts. The prolonged uncertainty around what was causing the infections and the risks associated with the building could not disappear, forming an ever-present background to healthcare operations on the site. Moreover, as set out already, the apparent reluctance of the Health Board to be more forthcoming about the risks and issues around water contamination was making this issue of how to be open about what was known, and what was not known, as critical for staff as it was for the children, young people and families.

Role of Senior Management in Communication

150. While frontline staff were seen as important communicators, especially by the patients and families, it was not always appropriate for them to communicate on issues related to more corporate responsibilities, and where high-level decisions (such as de-canting or temporarily closing wards) were being taken. The perception of some families was that frontline staff were 'unfairly' put in the position of communicating 'difficult' messages.

151. Moreover, there was a strong feeling among some families that senior management in NHS GGC were not sufficiently and consistently visible in speaking/communicating with them at an early stage. While acknowledging that communication roles were rightly placed at different management levels within such a large Health Board, the nature of the incidents, particularly when such disruptive steps such as de-canting had to be taken, required a clear and unequivocal demonstration of senior leadership in communication. Its perceived absence was regarded as a key factor in undermining family confidence in NHS GGC to address these issues.

152. Senior management in NHS GGC did remain close to the development of the issues at different stages, but the importance placed on what was happening to the children, young people and families was not always communicated widely and effectively by those with Executive responsibilities. There was a gap between the perception of some families that senior Board management in NHS GGC were not closely involved with the emerging infection issues and the evidence that they were being regularly monitored by the Executive team within NHS GGC. This appeared to be an issue of visibility in many cases, and in retrospect, there were missed opportunities to highlight the priority with which this was being considered at senior levels within NHS GGC. As the issues became more prominent in the media, several families commented that more direct engagement with more senior staff within NHS GGC at an earlier stage would have helped to bolster confidence, and defuse much of the tension that has continued to play out publicly.

153. Senior leaders within NHS GGC did become directly involved, with letters to families from the Chief Executive being issued later in this period and opportunities extended for families to meet with them. In this context, the Oversight Board welcomes the identification of the Nursing Director as the key Executive for communication with families by the Health Board. It further suggests that more visible senior leadership in communication with the public and with the children, young people and families at an earlier stage should be systematically considered to inform future practice.

Support from External National Bodies

154. The Health Board admitted that the complexity of the communication challenges meant that it could have benefitted from greater external support and advice in how to handle patient, family and public expectations. That support was not perceived to be present for much of the period, and indeed, it is not clear that this kind of support is regularly provided and coordinated across NHS Scotland. As a result, there is national learning to be gained in the external support and positioning around Board communication. The role and coordination of messaging by external

bodies, particularly HPS and the Scottish Government, could also improve to ensure that these issues are not regarded as exclusively local.

155. In this respect, the difficulties faced by NHS GGC should not be regarded as exclusive to it, but potentially something that can be shared by other Health Boards facing similar situations and acting within the existing expectations and approaches to communication. Just as there are national bodies on hand to provide centralised specialist expertise to the Health Board in terms of the IPC challenges, similar national consideration should be given to having analogous expertise and advice on communication and engagement as well.

Remaining Work

156. As well as a general responsibility to inform patients, families and the wider public through the infection incidents, the Health Board is subject to a series of specific duties to investigate, inform and enter into dialogue when harm occurs in hospital settings. These duties are governed by a range of legislative, regulatory and guidance frameworks, but they all require compliance of Health Boards in the fulfilment of defined actions. They include:

- the organisational duty of candour: this is a legal duty which sets out how organisations (such as Health Boards) should tell those affected that an unintended or unexpected incident appears to have caused harm or death, and which requires the organisations to apologise and meaningfully involve those affected in a review of what happened – the Communication and Engagement Subgroup has undertaken work on this area, but that work will need to be linked into the wider assessment of reviews set out below;
- reviews of Significant Adverse Incidents: a national framework now exists to provide an overarching approach for best practice in how care providers effectively manage adverse events; and
- morbidity and mortality reviews: the reviews of patient deaths or care complications are designed to support organisations improve patient care and provide professional learning.

157. It is important that the Oversight Board can provide assurance that these obligations and commitments to good practice were met during these incidents. The Oversight Board is continuing to review these matters and will report its findings in the Final Report.

Case Note Review

Background to the Case Note Review

158. As part of the work of the Oversight Board, the Cabinet Secretary for Health and Sport set out plans for a Case Note Review in a Parliamentary statement on 28 January 2020. The Case Review team would review the case notes of paediatric haemato-oncology patients in the QEUH and RHC from 2015 to 2019 who had a gram-negative environmental pathogen bacteraemia (and selected other organisms) identified in laboratory tests.

159. The Case Note Review is currently reviewing the clinical records of all children and young people diagnosed with qualifying infections and who were cared for at the QEUH and RHC between 1 May 2015 and 31 December 2019. It is focusing on several key aspects: the number of patients (in particular, immuno-compromised children and young people) who may have been put at risk because of the environment in which they were cared; and how that infection may have influenced their health outcomes. Such work will be vital in determining the number and nature of the children and young people affected, providing assurance and identifying improvement actions, not just for NHS GGC, but more widely across NHS Scotland. It is also an important element in improving the communication and engagement with the affected children and young people and their families.

160. The Review will consider the balance of probability on the following set of specific questions:

- *How many children in the specified patient population have been affected, details of when, which organism etc?*
- *Is it possible to associate these infections with the environment of the QEUH and RHC?*
- *Was there an impact on care and outcomes in relation to infection?*
- *What recommendations should be considered by NHS GGC – and, where appropriate, by NHS Scotland, more generally – to address the issues arising from these incidents to strengthen IPC in future?*

161. There are two specific sets of outputs:

- reporting to the Oversight Board; and
- specific feedback to patients and families (including responses to questions raised by individual families).

Reporting to the Oversight Board

162. The independent Expert Panel will be responsible for providing a Final Report to the Oversight Board, which will include:

- a description of the approach and methodology to the Review;
- a description of the children and young people included in the Review;
- a description of the cases according to specified data types;

- analysis to answer the questions set out above; and
- observations on any prior NHS GGC internal reviews of individual episodes of care
- recommendations for NHS GGC and NHS Scotland, based on this analysis.

Individual case details will not be set out in the Report and the cases will be anonymised. This Report will be published.

Reporting to Patients and Families

163. The Expert Panel will provide individual private reports to patients and families that have requested details of the results of the reviews on the experiences of the individual children and young people.

Progress Update

164. As with the work of the Oversight Board, the Case Note Review's timescales have been affected by the impact of the pandemic – however, its work has progressed, albeit at a slower pace. The Expert Panel has agreed a classification of relevant infecting organisms, and the case notes of all children and young people defined as follows:

- those with a gram-negative environmental bacteraemia (bloodstream infection) – most patients fall into this group;
- other environment-related infections – there are a few other types of infection which may be associated with the environment (such as *M. chelonae*), but this includes only a small number of cases, some with bloodstream infection and some with similar infections found at other sites; and
- a smaller number of individual children and young people identified for inclusion for special reasons, where concerns have been raised that are related to the issues affecting the QEUH/RHC.

Currently, 85 children and young people have been identified, and whose clinical records will be reviewed (some have had more than one 'qualifying' infection episode).

165. The Expert Panel has estimated that it will complete its review of the instances of infection and be presenting its report in early 2021.

Interim Report Findings and Recommendations

166. The core of the Oversight Board's work has been the issue of assurance. Escalation has arisen from a history of complex issues since at least the opening of the QEUH, but the primary matter that gave rise to escalation to Stage 4 was a question of the 'fitness for purpose' of NHS GGC relating to: how IPC is conducted; the way that clinical governance operates with respect to infections; and the communication and engagement approach to these events. Understanding the history of what has happened to the children, young people and the families in the paediatric haemato-oncology service and the clinicians that have supported them has been essential for the Oversight Board. Knowing this history is critical in ensuring that the right lessons have been learned and in further considering the current fitness of the structures and functions of NHS GGC within the Oversight Board's terms of reference.

167. Ultimately, the main question before the Oversight Board has been whether NHS GGC should be 'de-escalated' from Stage 4. As this is an Interim Report, the Final Report will provide a final assessment of all the issues that gave rise to escalation, the contributory factors and the learning and improvement evident to date. Notwithstanding that this remains work in progress, this Interim Report has already identified a number of areas where improvement needs to take place. This forms the basis for the findings and recommendations set out in this chapter, which also includes areas where further investigation is necessary (for example, with respect to the Peer Review). The Final Report will set out the conclusions from the rest of the Oversight Board's work, taking account of the Case Note Review, and provide the full list of recommendations and advice on de-escalation.

Findings

168. Findings are given for each of the different issues that led to the Health Board being escalated to Stage 4. Of the three areas for escalation, one – governance and risk management – has not been examined in detail in the Interim Report, so findings and recommendations are not presented for that set of issues. In addition, the work of the Technical Issues Subgroup has not been finalised for this report either, as noted above. Consequently, the findings here focus on major elements of the following areas: IPC; and communication and engagement.

Infection Prevention and Control: Processes, Systems and Approach to Improvement

169. Expectations around the scope and pursuit of IPC have changed over the last few years, reflecting, amongst other things, the impact of the Vale of Leven Inquiry. The Inquiry had a major impact on NHS GGC, of course, but it has changed the national context for ensuring that there are consistent, good-practice and evidenced approaches to effective, safe IPC. This has not been a single point of national transformation, but a continuing drive for improvement, one that will continue with the creation of a national centre of expertise for healthcare built environments. The constant evolution of a Scotland-wide agenda in IPC highlights both the challenges that the Health Board faced in addressing the infection incidents in the QEUH site – which presented complexities and unexpected issues that were far from recognised experience in Scotland – as well as the opportunities for using NHS GGC's learning to support NHS Scotland as a whole.

170. What has become clear is the importance of all Health Boards to balance a commitment to these national standards and the codified processes that they set out, rooted in evidence-based good practice, with the flexibility and professional judgement to go beyond set processes where required. Practice has been captured in national guidance and standards with clearly-established reporting and monitoring regimes. Finding that balance has been essential to be able to respond to the new situations and developments in infection control, as indeed, the current pandemic is exemplifying to an alarming degree.

171. NHS GGC showed itself capable on repeated occasions of achieving that balance. Outside of these infection incidents, the recognition of the need to drive improvement was present in its work on CLABSI (and more widely, *Methicillin-resistant Staphylococcus aureus* (MRSA)). In the series of gram-negative infection outbreaks, the Health Board could respond innovatively and positively, with examples including specific responses to incidents (such as the establishment of the Technical Water Group in response to the 2018 'water incident'). That work is continuing through the recent reforms put in place in NHS GGC through a new 'Gold Command' structure and the formation of a dedicated programme of work to support improvement in IPC with joint executive leadership from the IPC Team, hospital operations, and Facilities and Estates.

172. However, these instances were not sufficiently consistent to provide assurance. An improvement-based learning approach – vital in addressing circumstances as novel and challenging as the environmentally-based infections in the QEUH – did not appear to be mainstreamed across the organisation. A structured use of quality improvement and good learning in one area did not seem to be systematically mainstreamed across the organisation. The IPC Team was seen as remaining too siloed and not fulfilling its role as the service that embeds improvement and mainstreams good IPC across the Health Board. Recognising recent progress, the Oversight Board welcomes the NHS GGC's creation of a new IPC work programme, and believes that one of its early priorities must be how improvement principles can be deepened in its work.

173. Through the work of the Peer Review, the Oversight Board highlighted a number of specific processes where improvement was required.

- Health Board compliance with the NIPCM was translated through a profusion of additional local guidance and interpretations of national standards, which ran the risk of promoting a 'GGC way of doing things' rather than nationally-endorsed standards.
- HAI-SCRIBEs were not pursued with full diligence and fidelity to process. Too often there seemed to be 'shortcuts' being taken in how HAI-SCRIBEs were put together that suggested a lack of understanding behind the good practice captured in the NIPCM.
- Audit and surveillance showed an inconsistent approach to improvement overall, with insufficient follow-through actions on audits and the absence of a pro-active approach to additional environmental alert organisms in surveillance.
- The scoring of HIIATs raised some concerns that the Health Board was not giving full (and in the Oversight Board's view, necessary) consideration to the wider context of infection at the QEUH site when rating infections. Elements of this issue have a national dimension, and the Oversight Board recognises the opportunity to improve practice across all Health Boards. But in the context of the environmental risks in the

QEUH, the approach to HIIATs may indicate an underestimation of the wider infection risks facing the site.

174. The Peer Review could not be implemented in full by the Oversight Board because of the pandemic, and so the recommendations below recognise that there is further investigative work the Health Board should do for its IPC processes.

175. The Interim Report has focused on how the IPC Team tackles different aspects of IPC. The Final Report will focus on how the Health Board handled the specific incidents, and what that reveals of the way IPC is conducted by the Health Board.

Communication and Engagement

176. It is hard to imagine a group of children, young people and families for whom the principles of person-centred communication would be more relevant in a healthcare setting. Within the paediatric haemato-oncology service, families were experiencing the sustained impact of the problems in the clinical environment on their children, including significant disruption and uncertainty. Given the nature of the patients, there were high-risk consequences of the issues remaining unresolved – communication and engagement through regular, sensitively-presented and clear information was vital.

177. The Health Board seems to understand this. It espouses person-centred principles in its overarching communication strategies. Indeed, throughout its work, the Oversight Board was presented with a lot of good evidence of a compassionate approach to communication within NHS GGC, especially by staff at the point of care. Families singled out the medical and nursing staff for their support, not least in how they kept themselves and their children as well informed as they could, a clear reflection of the person-centred approach to discussing individual care with patients and families. At this level, transparency and sensitivity seems to be regularly balanced in a way that patients and families regard positively – albeit sometimes limited and constrained by the problems with corporate and senior management communication referred to in this report.

178. However such an approach is inconsistently applied across the organisation. When it comes to communication that goes beyond ward level, too many patients and families feel that it has not been actioned, timely or fulsome, and that they are too often the last to know. This sense accumulated over several years, and it currently strains relationships between some families and the Board (and in a few cases, contributed to those relationships breaking down). Several families have felt that the Board has been too slow, if not reluctant, to provide them with answers to their questions, and have developed a deepening view of a Health Board that cannot admit to mistakes – or even, simply acknowledge uncertainty – about the environment of the building or the care of their children. Wherever the causes lie with this, the results demonstrate a clear failure of the goals of communication for this group of children and young people and their families as a whole. Indeed, the appointment of Professor Craig White, in part a response to the gaps that had appeared between families and the Health Board, has been an acknowledgement of this.

179. From the Health Board's perspective, it is important to understand the challenges facing NHS GGC with communication.

- There was long-term uncertainty in how to explain the infection incidents, especially over the source of infections and the picture of environmental risk that started to appear.
- At some points over the period (notably in the aftermath of the *Cryptococcus neoformans* infections in early 2019), media coverage was experienced as a 'siege', heightening wariness of how public communication was managed. This created some logistical challenges in ensuring children, young people and their families were given correct information before any misleading or false news spread through the media.
- Those challenges were particularly acute in providing consistent and timely communication with patients and families no longer in regular contact with ward-based staff.

180. The Health Board mainstreamed a commitment to tailored and sensitive responses to individual patients and families through a database to reliably note individual family communication and information preferences. The creation of the closed Facebook page recognised that communication was not simply between individual patients and families with the Health Board, but amongst each other, as part of a community sharing the common experience of a child or young person in contact with the service and concerned by the impact of infection issues on their child's care experience and outcome.

181. The gradual unfolding of the scale of problems at the QEUH, with the emergence of hypotheses relating to the environment and building that could not be quickly verified or discounted, presented particular challenges in communication. The responsibility for decisions in respect of communication about incidents and outbreaks is typically lodged with IMTs, with communication advisors providing support for discussions to inform decisions by IMT chairs. While IMTs were active through this period in response to the infections, the IMT process itself – useful in more incident-based situations – was potentially less effective for a continuing 'crisis'. A new, or at the very least, enhanced process may need to be identified to address this with national support.

182. The recent legal action against the builders of the QEUH complex seems to be complicating the ability of the Health Board to be as open and responsive as patients and families need. There is a risk of the Health Board becoming increasingly reluctant to comment or discuss aspects of what has happened in relation to the infection incidents, citing the risks of compromising the forthcoming legal case. This has exacerbated a sense among several families that NHS GGC has not been pursuing a policy that gives primacy to transparency and sensitivity to the affected children, young people and families. While the Oversight Board appreciates the legal issues facing NHS GGC, it considers that alternative approaches were and are possible and that the current continuing silence on many of these issues will not address fundamental concerns on communication and engagement that gave rise to escalation to Stage 4.

183. Lastly, there is a national dimension to this as well. Just as with other aspects of healthcare, there is a clear value in pooling experience and practice in NHS Scotland to address complicated communication challenges and developing national expertise. External bodies such as HPS and others did not have the expertise to providing NHS GGC with advice and support in this area. While the responsibilities may fall locally to NHS GGC, the implications are Scotland-wide, and deserve the same approach to improvement and learning found in other areas of healthcare.

Recommendations

184. The recommendations of the Oversight Board are rooted in the findings described above. As noted earlier, there are important lessons for NHS Scotland as a whole as well as specifically for NHS GGC – indeed, the unusual experiences of the Health Board could provide important lessons for Scotland. The Oversight Board has been well aware of the novelty of the challenges faced by the Health Board, the absence of national guidance in some areas and the importance of making an assessment that is not distorted by hindsight.

185. The recommendations are based on what needs to be done by NHS GGC to provide assurance and address escalation. In terms of the Key Success Indicators of the Oversight Board, they identify the changes that are required to satisfy the Oversight Board that these success indicators will be met and assurance restored, at least for the areas reviewed in the Interim Report. The recommendations are grouped according to each set of escalation issues: IPC; and communication and engagement. National recommendations are set out in the **green** boxes below.

Infection Prevention and Control: Processes, Systems and Approach to Improvement

186. The Interim Report recommendations cover the following key areas:

- the degree to which specific IPC processes in the QEUH have been aligned with national standards and good practice; and
- the extent to which the IPC Team has demonstrated a sustained commitment to improvement in infection management across NHS GGC.

Recommendation 1: With the support of ARHAI Scotland, NHS GGC should undertake a wide-ranging benchmarking of key IPC processes through a more comprehensive Peer Review exercise.

187. With support from ARHAI Scotland, NHS GGC should undertake a comprehensive Peer Review process, led from within its IPC Team but drawing on external expertise. The scope and terms of reference should be agreed with the Scottish Government by the end of January 2021, and should include elements that were not examined as part of the Oversight Board's Peer Review in March 2020, specifically outbreak and incident investigation, and water safety.

188. This Peer Review should be undertaken as soon as feasible (acknowledging the pressure of other circumstances, not least the pandemic), and completed before the end of March 2021. The recommendations of that Peer Review should be jointly presented to the NHS GGC Board and the Scottish Government, and the former should authorise an action plan to implement any relevant recommendations.

Recommendation 2: With the support of ARHAI Scotland, NHS GGC should review its local translation of national guidance (especially the National Infection Prevention and Control Manual) and its set of Standard Operating Procedures to avoid any confusion about the clarity and primacy of national standards.

189. NHS GGC has not applied the NIPCM as fully and transparently as it could. Moreover, there was a view that not all guidance in the NIPCM was appropriate for NHS GGC. Consequently, NHS GGC should conduct a review of its guidance portal so that clinical staff are referred to the NIPCM and all relevant national guidance (as set out in DL 2019 (23)) more clearly as a single 'point of truth'. This should build on progress already made to feed into national structures, minimising the development of new local guidance. This exercise should set clear, consistent principles for the development of local translations of national guidance, as well as the responsibility for developing, implementing and overseeing the relevant set of standards/guidance. This should be completed by end March 2021 and the results presented to the Scottish Government.

Recommendation 3: ARHAI Scotland should review the National Infection Prevention and Control Manual in light of the QEUH infection incidents.

190. Surveillance issues need to be addressed at national level as well. ARHAI Scotland should review the NIPCM to consolidate and prioritise content in relation to alert organism surveillance. In particular, Appendix 11 and the A-Z guidance list of organisms of the national manual should be enhanced as required so there is national consistency to any aide-memoires developed for clinical staff to use locally. The guidance could benefit from additional disease-specific evidence-based SOPs or aide-memoires for some novel pathogens to be produced nationally. This review should be taken forward in collaboration with the Scottish Government and completed by end June 2021.

Recommendation 4: With the support of Health Facilities Scotland, NHS GGC should undertake an internal review of current Healthcare Associated Infection Systems for Controlling Risk in the Build Environment (HAI-SCRIBE) practice to ensure conformity with relevant national guidance.

191. NHS GGC should undertake an internal review of current HAI-SCRIBE practice against SHFN 30 to check that HAI-SCRIBEs are being developed consistently across the whole of NHS GGC and in line with national guidance. This review should include: the level of engagement and input from the IPC Team to take account of level of risk, as well as the scale of the project; the level and nature of the required input from the IPC Team for projects which are deemed smaller; and the overall use of HAI-SCRIBE and the consistency of use across NHS GGC, including consistency training for those undertaking HAI-SCRIBE. The review should be undertaken in cooperation with HFS and the results presented to the Scottish Government by end March 2021.

Recommendation 5: Health Facilities Scotland should lead a programme of work to provide greater consistency and good practice across all Health Boards with respect to the use of HAI-SCRIBEs.

192. HFS should work with Health Boards across Scotland to develop a governance system for ensuring HAI-SCRIBEs are completed consistently across and within all Health Boards. This should entail the establishment of a national forum to enable better sharing of design issues and lessons learned, with plans and a timetable for the forum to be agreed with the Scottish Government by March 2021. This should be supported by a review of the current HAI-SCRIBE guidance across all Health Boards, which should be led by HFS in cooperation with the Scottish Government and completed by end June 2021.

Recommendation 6: With the support of Healthcare Improvement Scotland, NHS GGC should undertake a review of its programme of audits relating to IPC, in line with the national Healthcare Improvement Scotland framework for quality planning and improvement.

193. A review of audit programmes should be undertaken to ensure consistency in RAG rating and a stronger link to a continuing culture of improvement. This would help to confirm that there is an organisational approach to safe care auditing, in particular ensuring that it is not the sole responsibility of the IPC team. This should be done in the context of existing Quality Framework for improvement and planning as set out by HIS and involve the latter in a support role. The scope of the review should be agreed with the Scottish Government and completed by end March 2021.

Recommendation 7: ARHAI Scotland should review the existing national surveillance programme with a view to ensuring there is a sustained programme of quality improvement training for IPC Teams in each Health Board, not least with respect to surveillance and environmental infection issues.

194. IPC teams across Scotland are involved in vast amount of data collection in terms of audit and surveillance. It is vital that this data is used to support both local and national quality improvement in terms of patient outcomes. The Oversight Board recommends that this should include:

- a national surveillance system for Scotland which would seamlessly follow each patient across each interface of health and care – this would ensure that IPC and HP teams have the ability to act timeously where there individuals who may pose a public health risk, such as those who are isolating multi-drug resistant organisms; and
- provision of training for IPC teams regarding quality improvement, utilising the data and intelligence from both audit and surveillance to ensure better outcomes for patients.

ARHAI Scotland, working with the Scottish Government, should set out plans for the required programme of work before the end of June 2021, potentially using the national forum referenced in Recommendation 5 above to develop and monitor the work going forward.

Recommendation 8: With the support of ARHAI Scotland, NHS GGC should undertake a review of its approach to Healthcare Infection Incident Assessment Tools (HIIATs) to ensure that risks and incidents are being properly and consistently identified and communicated.

195. As seen above, the rating of HIIATs for the relevant infections in the QEUH raised concerns about consistency for the Oversight Board. A more in-depth and wide-ranging review needs to be undertaken by NHS GGC, with support from ARHAI Scotland, looking at the local criteria and judgements applied to ratings for infection incidents related to the QEUH. The results of the review should be presented to the Scottish Government by end March 2021.

196. Particular attention should be given to how known environmental risks in the hospital, especially with respect to potential water contamination, are explicitly factored into assessment. This should be part of a wider approach by the IPC Team to consider how the 'history' of environmental infections in the hospital site, particularly with respect to water contamination, can inform relevant IPC hypotheses and the work of IMTS more consistently going forward. The Health Board is invited as part of the review to set out how any change in HIIAT approach is mainstreamed across the wider approach to IPC, particularly in the QEUH.

Recommendation 9: ARHAI Scotland should lead on work to develop clearer guidance and practice on how HIIAT assessments should be undertaken for the whole of NHS Scotland.

197. The review of HIIATs found that national improvement is needed. All Health Boards should be encouraged to report all infection-related incidents in an open and transparent manner. To support this nationally, by the end of June 2021:

- ARHAI Scotland should further develop the HIIAT assessment and reporting tools to allow service, ARHAI Scotland and the Scottish Government to visualise easily all incidents within a healthcare facility over time;
- ARHAI Scotland should coordinate a working group through the NIPCM steering group to consider the HIIAT assessment more generally, including a standardised scoring system to provide a more robust risk assessment of infection-related incidents within care systems;
- a programme of work to improve national guidance and good practice should be drawn up to ensure NHS Boards and other organisations IMT consider previous incidents and any possible links when assessing all new infection-related incidents;

- a programme of work to develop education tools nationally to assist staff responsible for assessing and reporting infection-related incidents across NHS Scotland; and
- the Scottish Government should consider the communication and escalation process for all incidents, including a 'green' HIIAT.

Recommendation 10: A NHS GGC-wide improvement collaborative for IPC should be taken forward that prioritises addressing environmental infection risks an ensuring that IPC is less siloed across the Health Board.

198. The Oversight Board welcomes the development of a new improvement collaborative for IPC, and suggests that it takes forward early priorities that address the findings and recommendations set out here. As part of this, to ensure that IPC is more effectively mainstreamed across the different parts of the organisation, a cross-NHS GGC exercise should be undertaken to develop a plan for ensure IPC operates in a less siloed fashion across different service/functions in the Board. That exercise should consider the role of the IPC Team and the aspects of IPC that should be the responsibility of other parts of the organisation and other teams. It should undertake any necessary benchmarking with other Health Boards. The results of the work should be considered by the Board Infection Control Committee and the Clinical Care and Governance Committee. Monitoring arrangements for implementing the plan should be clearly set out as part of this.

199. The scope of the work should be agreed with the Scottish Government and the Health Board by end January 2021 and the work completed by end June 2021.

Communication and Engagement

200. Recommendations are set out below with respect to the overarching question: ***is communication and engagement by NHS GGC adequate to address the needs of the children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?*** Issues relating to the organisational duty of candour and review processes such as Significant Adverse Event Reviews will be discussed in the Final Report.

Recommendation 11: NHS GGC should pursue more active and open transparency by reviewing how it has engaged with the children, young people and families affected by the incidents, in line with the person-centred principles of its communication strategies. That review should include close involvement of the patients and families themselves.

201. The particular problems of communicating information on HAI in the paediatric haemato-oncology service – when key information remains uncertain, or at best, nuanced – was acknowledged by the Oversight Board. It was challenging for NHS GGC to balance assurance in its approach to addressing the infection incidents when there was continuing, longer-term uncertainty on the sources of infection. Nevertheless, the focus should remain on transparency and this did not appear to be consistently applied by NHS GGC.

202. In that context, it is vital that there is clear and widespread consistency of messages and information shared in these situations. Similarly, it is critical that the Health Board undertakes a more transparent approach in its communication against any similar background of uncertainty, even if it leads to NHS GGC admitting its inability to answer key questions immediately. Expressing uncertainty should not be seen as detracting from providing reassurance. The Health Board should be more open about what is known and what can be said.

203. This should form the governing principles of a NHS GGC review of how it undertook communication with the affected children, young people and families of the infection incidents and what learning should be taken and mainstreamed. That review should closely involve the families themselves and be presented to the Scottish Government by end March 2021, not least as a source of national learning for other Health Boards. It should focus on the transparency and timeliness of how information was presented and communication experienced by patients and families.

Recommendation 12: NHS GGC should ensure that the recommendations and learning set out in this report should inform an updating of the Healthcare Associated Infection Communications Strategy and an accompanying work programme for the Health Board.

204. NHS GGC should review and renew its existing HAI Communication. A revised strategy – taking account of the learning set out in this report and the actions identified in the recommendations – could become the basis of an exemplar to other Boards, or a plan modelled on national strategic and IPC requirements. This should be completed by end March 2021.

205. Communication and engagement activities were being brigaded together under a 'Silver Command' strand in the new 'Gold Command' structure. As the 'Better Together' work strand develops, there should be a priority in developing a revised version of the strategy with an accompanying action plan and commitment to undertake the reviews set out in these Interim Report recommendations.

Recommendation 13: NHS GGC should make sure that there is a systematic, collaborative and consultative approach in place for taking forward communication and engagement with patients and families. Co-production should be pursued in learning from the experience of these infection incidents.

206. The experience of the communication on HAI in the paediatric haemato-oncology service has highlighted the need for deploying a range of approaches. This should be routinely pursued through collaborative work with families with direct experience of how best to navigate the complexities of making contact when an organisational or public interest matter may require that. A partnership approach should be explicitly recognised by NHS GGC and actively pursued as part of the 'Silver Command' work programme and reflected in the HAI Communication Strategy referenced in the previous recommendation.

Recommendation 14: NHS GGC should embed the value of early, visible and decisive senior leadership in its communication and engagement efforts and, in so doing, more clearly demonstrate a leadership narrative that reflects this strategic intent.

207. Leadership in addressing the challenge of communication on HAI in the paediatric haemato-oncology service was clearly demonstrated in much of the response to the emerging issues by some senior staff within the hospital. But more senior leadership within the Health Board was not always presented visibly or experienced positively by the children, young people, their families and the public as the situation unfolded in the public eye. The lack of consistency in the approach was a significant issue for some families.

208. NHS GGC should review its approach to ensuring the right tone and sensitivity in handling is pursued in future, especially for its corporate communication, and determine if guidance or training is required to embed the Health Board's learning in this context. There should be more systematic assurance by the Health Board that this is happening across the organisation. This should also ensure that the views and experiences of patients and families remain central to how excellence in healthcare is pursued. Regular reviews of patient experiences and the use of Care Opinion is good, but opportunities for a more targeted review of communication in key incidents by relevant patients and families should be considered. This should build on the recent work led by the Executive Nurse Director as presented to the Board's Clinical and Care Governance Committee. This could take the form of some form of regular monitoring/review on the quality and effectiveness of communication in IPC as part of the revised HAI strategy. The results of that review should be regularly presented to the CCGC, and, where appropriate, the Board.

209. The Health Board should present a proposal for putting these measures in place to the Scottish Government by the end of January 2021 so that it can feed into the development of a revised HAI Strategy.

Recommendation 15: The experience of NHS GGC should inform how all of NHS Scotland can improve communication with patients and families 'outside' of hospitals in relation to infection incidents.

210. There was a challenge for NHS GGC in communicating when it was not person-to-person. That challenge should be explicitly recognised and addressed pro-actively by the Health Board in preparation for any similar future challenges by ensuring its communication infrastructure has a strategic emphasis that recognises and plans and delivers on these principles. This includes due recognition of the role of strategic intent, leadership, skills and culture.

211. That should include learning from and establishing as routine practice the establishment of specific communication channels for patients and families. The example of the 'closed' Facebook page has already been cited, and while it remains a 'work in progress',

it has been a key element in restoring good communication with many of the families including a significant uptake in participation. There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communication group in the first half of 2021.

Recommendation 16: The experience of NHS GGC in systematically eliciting and acting on people's personal preferences, needs and wishes as part of the management of communication in these infection incidents should be shared more widely across NHS Scotland.

212. To ensure that people remain at the centre of communication and engagement efforts and that they are listened to, special attention should be placed on ways of capturing communication preferences. This is particularly critical in particular operational services such as paediatric haemato-oncology service. NHS GGC demonstrated useful learning in this context, particularly through the development, updating and use of its database of communication preferences for affected patients and families. There is an excellent opportunity for national learning, and it is recommended that NHS GGC pursues this through the NHS Scotland strategic communication group. It should share learning of the use of the shared database (both software and approach) as well as the mechanism they developed to have single list of all those across service elements receiving care.

Recommendation 17: NHS GGC should learn from other Health Boards' good practice in addressing the demand for speedier communication in a quickly-developing and social media context. The issue should be considered further across NHS Scotland as a point of national learning.

213. The impact of social media on amplifying speculation was presented by NHS GGC as a key challenge, often overwhelming messages, narrative, and the ability to reassure families and present clear information. The Health Board should consider how it can provide more adept and quicker confirmation of lines and messages in this context, guarding against any harmful lag in communication, and how best to make positive and effective use of social media in this context. There is good practice that can be learnt from other Boards around the use of social media in this context, particularly around the value of different types of social media in different contexts. This is an excellent opportunity for national learning, and should be pursued through the NHS Scotland strategic communication group in the first half of 2021.

Recommendation 18: NHS GGC should review and take action to ensure that staff can be open about what is happening and discuss patient safety events promptly, fully and compassionately.

214. Good communications with the staff is important to ensure that staff are well informed and can contribute to supporting the children, young people and their families. This

only works if there is a good flow of information from the Board to the point of care, without internal organisational boundaries becoming barriers. Key factors to support this include active, transparent and consistent communication across different, relevant parts of the Health Board. This is also likely to involve empowering and supporting 'clinical voices' to lead, shape and deliver public-facing communication reflecting transparent, respectful and compassionate communication, including the improved use of clinical expertise and voices in corporate responses to media enquiries and briefings.

215. NHS GGC is invited to review its the experience of the communications on HAI in the paediatric haemato-oncology service, and where lessons learned can improve staff communication in future. Plans for taking this forward should be presented to the Scottish Government by end January 2021.

Recommendation 19: The Scottish Government, with Healthcare Improvement Scotland and ARHAI Scotland, should review the external support for communication to Health Boards facing similar intensive media events.

216. While communication and engagement in these circumstances can and should be the responsibility of individual Boards, there are points where there is a clear role of other key bodies in supporting messaging and the flow of information. That role was not clearly and consistently acted upon in these circumstances. Scottish Government, HIS and ARHAI Scotland should review how other bodies should support and engage with individual Boards in similar situations in future, through the NHS Scotland strategic communication group. The Scottish Government should ensure any plans for improvement are developed by end June 2021.

Annex A: Terms of Reference for the Oversight Board and its Subgroups

Oversight Board

Authority

The Oversight Board for the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC), NHS GGC (hereinafter, "the Oversight Board") is convened at the direction of the Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland, further to his letter of 22 November 2019 to the Chairman and Chief Executive of NHS GGC. These terms of reference have been set by the Director General, further to consultation with the members of the Oversight Board.

Purpose and Role

The purpose of the Oversight Board is to support NHS GGC in determining what steps are necessary to ensure the delivery of and increase public confidence in safe, accessible, high-quality, person-centred care at the QEUH and RHC, and to advise the Director General that such steps have been taken. In particular, the Oversight Board will seek to:

- ensure appropriate governance is in place in relation to infection prevention, management and control;
- strengthen practice to mitigate avoidable harms, particularly with respect to infection prevention, management and control;
- improve how families with children and young people being cared for or monitored by the haemato-oncology service have received relevant information and been engaged with;
- confirm that relevant environments at the QEUH and RHC are and continue to be safe;
- oversee and consider recommendations for action further to the review of relevant cases, including cases of infection;
- provide oversight on connected issues that emerge;
- consider the lessons learned that could be shared across NHS Scotland; and
- provide advice to the Director-General of Health and Social Care in the Scottish Government and Chief Executive of NHS Scotland about potential de-escalation of the NHS GGC from Stage 4.

Background

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement issues, the Director General for Health and Social Care and Chief Executive of NHS Scotland has concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage

4 of the Performance Framework. This stage is defined as ‘significant risks to delivery, quality, financial performance or safety; senior level external transformational support required’.

Approach

The Oversight Board will agree a programme of work to pursue the objectives described above. In this, it will establish subgroups with necessary experts and other participants. The remit of the subgroups will be set by the chair of the Oversight Board, in consultation with Board members. The Board will receive reports and consider recommendations from the subgroups.

In line with the NHS Scotland escalation process, NHS GGC will work with the Oversight Board to construct required plans and to take responsibility for delivery. The NHS GGC Chief Executive as Accountable Officer continues to be responsible for matters of resource allocation connected to delivering actions agreed by the Oversight Board.

The Oversight Board will take a values-based approach in line with the Scottish Government’s overarching National Performance Framework (NPF) and the values of NHS Scotland.

The NPF values inform the behaviours people in Scotland should see in everyday life, forming part of our commitment to improving individual and collective wellbeing, and will inform the behaviours of the Oversight Board individually and collectively:

- to treat all our people with kindness, dignity and compassion;
- to respect the rule of law; and
- to act in an open and transparent way.

The values of NHS Scotland are:

- care and compassion;
- dignity and respect;
- openness, honesty and responsibility; and
- quality and teamwork.

The Oversight Board Members will endeavour to adopt the NPF and NHS Scotland values in their delivery of their work and in their interaction with all stakeholders.

The OB’s work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives and also NHS GGC staff.

The Oversight Board is focused on improvement. Oversight Board members, and subgroup members, will ensure a lessons-learned approach underpins their work in order that learning is captured and shared locally and nationally.

Meetings

The Oversight Board will meet weekly for the first four weeks and thereafter meet fortnightly. Video-conferencing and tele-conferencing will be provided.

Full administrative support will be provided by officials from CNOD. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant CNOD staff. The Chairman and Chief Executive of NHS Greater Glasgow and Clyde will also receive copies of the papers.

Objectives, Deliverables and Milestones

The objectives for the Oversight Board are to:

- improve the provision of responses, information and support to patients and families;
- if identified, support any improvements in the delivery of effective clinical governance and assurance within the Directorates identified;
- provide specific support for infection prevention and control, if required;
- provide specific support for communication and engagement; and
- oversee progress on the refurbishment of Wards 2A/B and any related facilities and estates issues as they pertain to haemato-oncology services.

Matters that are not related to the issues that gave rise to escalation are assumed not to be in scope, unless Oversight Board work establishes a significant link to the issues set out above.

In order to meet these objectives, the Oversight Board will retrospectively assess issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement; having identified these issues, produce a gap analysis and work with NHS GGC to seek assurance that they have already been resolved or that action is being taken to resolve them; compare systems, processes and governance with national standards, and make recommendations for improvement and how to share lessons learned across NHS Scotland. The issues will be assessed with regards to the information available at the particular point in time and relevant standards that were extant at that point in time. Consideration will also be given to any subsequent information or knowledge gained from further investigations and the lessons learned reported.

Governance

The Oversight Board will be chaired by the Chief Nursing Officer, Professor Fiona McQueen, and will report to the Director General for Health and Social Care.

Membership

Member	**Job Title**
Professor Fiona McQueen (Chair)	Chief Nursing Officer, Scottish Government
Keith Morris (Deputy Chair)	Medical Advisor, Chief Nursing Officer's Directorate

	(CNOD), Scottish Government
Professor Hazel Borland	Executive Director of Nursing, Midwifery and Allied Health Professionals and Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran
Professor Craig White	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Dr Andrew Murray	Medical Director, NHS Forth Valley and Co-chair of Managed Service Network for Children and Young People with Cancer
Professor John Cuddihy	Families representative
Lesley Shepherd	Professional Advisor, CNOD, Scottish Government
Alan Morrison	Health Finance Directorate, Scottish Government
Sandra Aitkenhead	CNOD, Scottish Government (secondee)
Greig Chalmers	Interim Deputy Director, CNOD, Scottish Government
Carole Campariol-Scott/ Jim Dryden/ Calum Henderson/ Phil Raines (Secretariat)	CNOD, Scottish Government

The Co-chair of Area Partnership Forum and the Chair of the Area Clinical Forum will be in attendance at the meetings. In addition to these members, other attendees may be present at meetings based on agenda items, as observers: senior executives and Board Members from NHS GGC including, Medical Director, Nurse Director, Director of Facilities and estates, Director of Communications, Board Chair and Chief Executive; and representatives from HPS, HFS, HIS, HEI and HSE.

Stakeholders

The Oversight Board recognises that a broad range of stakeholder groups have an interest in their work, and will seek to ensure their views are represented and considered. These stakeholders include:

- patients, service users and their families;
- the general public;
- the Scottish Parliament;
- the Scottish Government, particularly the Health and Social Care Management Board;
- the Board of NHS GGC and the senior leadership team of NHS GGC; and
- the staff of NHS GGC and Trade Unions.

Special focus will be given to patients of the haemato-oncology service and their families, as highlighted by their direct involvement in the Communication and Engagement Subgroup.

Infection Prevention and Control, and Governance Subgroup

Purpose and Role

The Infection Prevention and Control Governance (IPCG) Subgroup for the NHS GGC Scottish Government Oversight Board is a time-limited group which has been convened to work with NHS GGC to:

- determine whether appropriate Infection Prevention and Control Governance is in place across the organisation to increase public confidence; and
- make recommendations, if required and where appropriate, to strengthen current approaches to mitigate avoidable infection harms

The IPCG Subgroup directly reports to the Oversight Board, which is chaired by the Chief Nursing Officer, Professor Fiona McQueen. It has specific responsibilities for supporting the Oversight Board to ensure, where necessary and appropriate, improvements are made in the delivery of effective governance and provide assurance relating to infection prevention and control within and across NHS GGC.

Background

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement issues, the Director General for Health and Social Care and Chief Executive of NHS Scotland has concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and, therefore, that for this specific issue the Board was escalated to Stage 4 of the performance framework. This stage is defined as ‘significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.’

The IPCG Subgroup will focus on issues relating to infection prevention and control and associated governance that gave rise to escalation to Stage 4.

Approach

The IPCG Subgroup will take a values based approach in line with NPF and the values of NHS Scotland.

The NPF values inform the behaviours people in Scotland should see in everyday life, forming part of our commitment to improving individual and collective wellbeing, and will inform the behaviours of the Oversight Board individually and collectively:

- to treat all our people with kindness, dignity and compassion;
- to respect the rule of law; and
- to act in an open and transparent way.

The values of NHS Scotland are:

- care and compassion;
- dignity and respect;
- openness, honesty and responsibility; and
- quality and teamwork.

These values will be embedded in the work of the IPCG Subgroup and will be informed by engagement work undertaken with key stakeholder groups.

The Subgroup is focused on improvement and as such the Subgroup members will ensure an evidence based, risk based, lessons-learned approach underpins their work in order that assurance can be articulated and learning is captured and shared both locally and nationally.

Meetings

The Subgroup will meet frequently for the first four weeks, with frequency thereafter to be determined as required. Video-conferencing or tele-conferencing will be provided.

Full administrative support will be provided by officials from CNOD. The circulation list for meeting details/agendas/papers/action notes will comprise Subgroup members, their PAs and relevant CNOD staff.

Objectives

The objectives for the Subgroup are to:

- carry out a system wide review of current systems and processes relating to the infection prevention and control and associated governance scheme of delegation and escalation mechanisms against relevant national standards and guidance;
- determine if there are any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to IPC risk management, audit, performance, compliance and assurance;
- provide support to the IPC Team within NHS GGC in the identification of measures for assurance as part of the review process and for future improvement/implementation; and
- make recommendations where appropriate to the Oversight Board on areas of learning for other Health Boards

In Scope

In order to meet these objectives, the Subgroup will retrospectively assess systems, processes and governance arrangements in relation to IPC management and control across the whole of NHS GGC. It will do so by reviewing:

- alignment of IPC and wider Board structures within the span of influence of NHS GGC; and
- a range of reports considered by the Board Corporate Governance Committees and the network of Operational Governance Groups and Committees including those reports presented to the associate Integrated Joint Boards.

Deliverables will be agreed in the early meetings of the Subgroup and with the Oversight Board.

Out of Scope

The Subgroup will not review:

- roles and responsibilities of individual staff members within NHS GGC; and
- aspects covered by either the Communication and Engagement or Technical Subgroups of the Oversight Board.

Governance

The Subgroup will be chaired by Diane Murray, and will report to the Chair of the Oversight Board.

Member	Job Title
Diane Murray (Chair)	Deputy Chief Nursing Officer, Scottish Government
Hazel Borland	Executive Director of Nursing, Midwifery and Allied Health Professionals and Healthcare Associated Infection Executive Lead, NHS Ayrshire and Arran
Professor Angela Wallace	Nurse Director, NHS Forth Valley
Professor Craig White	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Frances Lafferty	Infection Control Nurse, NHS Ayrshire and Arran
Martin Connor	Infection Control Doctor, NHS Dumfries and Galloway
Helen Buchanan	Executive Director of Nursing, Midwifery and Allied Health Professionals and Healthcare Associated Infection Executive Lead, NHS Fife
Christina Coulombe	Infection Control Manager, NHS Lanarkshire
Lisa Ritchie	Nurse Consultant, Health Protection Scotland, NHS National Services Scotland
Professor Marion Bain	Director for Infection Prevention and Control, NHS GGC (secondee)
Phil Raines	Chief Nursing Officer's Directorate (CNOD), Scottish Government
Sandra Aitkenhead	CNOD, Scottish Government (secondee)
Lesley Shepherd	Professional Nurse Advisor, CNOD, Scottish Government
Carole Campariol-Scott/ Jim Dryden/ Calum Henderson (Secretariat)	CNOD, Scottish Government

Associated Participant	Job Title
Sandra Devine	Infection Control Manager, NHS GGC
Pamela Joannidis	Infection Control Nurse, NHS GGC
Dr. A Leonard	Infection Control Doctor, NHS GGC
Dr. J Armstrong	Medical Director, NHS GGC
Elaine Vanhegan	NHS GGC Board Governance Lead

NHS GGC may have other officers in attendance dependant on the issue being discussed and agreed through the chair.

Technical Issues Subgroup

Authority

The Oversight Board for the QEUH and RHC, NHS GGC has been established at the direction of the Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland, further to his letter of 22 November 2019 to the Chairman and Chief Executive of NHS GGC.

A technical subgroup of the Oversight Board has been established to provide technical review, advice and assurance on the relevant technical matters relating to the built environment of the hospitals.

Purpose and Objectives

The purpose of the Technical Subgroup is to support the work of the Oversight Board, with a particular focus on the technical workings of the hospitals and any related technical reviews or reports. In particular the Technical Subgroup will:

- confirm that relevant environments at the QEUH and the RHC are and continue to be safe;
- oversee progress on the refurbishment and reopening of Wards 2A/B at the RHC and any related facilities and estates issues as they pertain to haemato-oncology services, such as Ward 6A at the QEUH;
- ensure that there are appropriate action plans in place to address any technical issues highlighted by competent authorities such as the Health and Safety Executive, Health Protection Scotland or Health Facilities Scotland and that these action plans are being delivered and provide oversight on connected issues that emerge;
- consider the lessons learned that could be shared across NHS Scotland; and
- provide advice to Oversight Board about potential de-escalation of the NHS GGC Board from Stage 4, in relation to these issues.

Background

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement issues, the Director General for Health and Social Care and Chief Executive of NHS Scotland has concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of the Performance Framework. This stage is defined as ‘significant risks to delivery, quality, financial performance or safety; senior level external transformational support required’.

Approach

The Oversight Board is required to establish subgroups with necessary experts and other participants; this subgroup will address the requirement to ensure that relevant environments at the QEUH and RHC are and continue to be safe. To ensure delivery of that overarching

objective, the Technical Subgroup will agree a programme of work to ensure that it complies with the purpose and objectives of the group.

The Oversight Board, and its subgroups, is focused on improvement. Members of this subgroup, will ensure a lessons-learned approach underpins their work in order that learning is captured and shared locally and nationally.

Governance/Accountability

The Subgroup will be chaired by the Alan Morrison, Health Finance and Infrastructure, Scottish Government and will report direct to the Oversight Board.

Membership

Member	Job Title
Alan Morrison (Chair)	Health Finance Directorate, Scottish Government
Tom Steele	Director of Estates, NHS GGC
Gerry Cox	Deputy Director of Estates, NHS GGC
Ian Storrar	Principal Engineer, Health Facilities Scotland
Lisa Ritchie	Nurse Consultant, Health Protection Scotland, NHS National Services Scotland
Sandra Aitkenhead	Chief Nursing Officers Directorate (CNOD), Scottish Government (secondee)
Phil Raines	CNOD, Scottish Government
Calum Henderson (Secretariat)	CNOD, Scottish Government

Additional involvement will be requested as necessary.

Communication and Engagement Subgroup

Purpose and Role

The Communication and Engagement Subgroup is a time-limited group to offer advice and assurance working with the Scottish Government and NHS GGC on:

- effective communication and engagement with patients and families; and
- robust, consistent and reliable person-centred engagement and communication.

Background

In light of the on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the QEUH and RHC and the associated communication and public engagement issues, the Director General for Health and Social Care and Chief Executive of NHS Scotland has concluded that further action is necessary to support the Board to ensure appropriate governance is in place to increase public confidence in these matters and therefore that for this specific issue the Board will be escalated to Stage 4 of the performance framework. This stage is defined as ‘significant risks to delivery, quality, financial performance or safety; senior level external transformational support required.’

Approach

The Communication and Engagement Subgroup will take a values based approach in line with the NPF and the values of NHS Scotland. The NPF values inform the behaviours people in Scotland should see in everyday life, forming part of our commitment to improving individual and collective wellbeing, and will inform the work of the Subgroup individually and collectively:

- to treat all our people with kindness, dignity and compassion;
- to respect the rule of law; and
- to act in an open and transparent way.

The values of NHS Scotland are:

- care and compassion;
- dignity and respect;
- openness, honesty and responsibility; and
- quality and teamwork.

These values will be embedded in the work of the Communication and Engagement Subgroup, and this work will also be informed by engagement work undertaken with other stakeholder groups, in particular family members/patient representatives, respecting the importance of specific values informed actions linked to personal context and experiences.

The Communication and Engagement Subgroup is focused on improvement. Subgroup members, will ensure a 'lessons learned' approach, as well as respecting the experience of families must underpin and inform the identification of improvements for dissemination both locally and nationally.

Meetings

The Communication and Engagement Subgroup will meet fortnightly initially and then at a frequency to be determined thereafter. Tele-conferencing will be provided.
A range of communication and engagement mechanisms will be agreed to enable patients and families to feed into the work of the Communication and engagement Subgroup.

Full administrative support will be provided by officials from Scottish Government. The circulation list for meeting details/agendas/papers/action notes will comprise Oversight Board members, their PAs and relevant CNOD staff.

Outcomes

The Outcomes for the Communication and Engagement Subgroup are to:

- positively impact on patients and their families in relation to how complex infection control issues and all related matters are identified, managed and communicated;
- demonstrate a pro-active approach to engagement, communication and the provision of information; and

- identify what has worked well and where the provision of information, communication and engagement could have been and could be enhanced and improved.to ensure that the outputs from the group are disseminated to key stakeholders and any wider learning points or recommendations are shared nationally.

In order to achieve these outcomes, the Subgroup will retrospectively assess factors influencing the approach to communication and public engagement associated with the infection prevention and control issues and related matters at the QEUH and RHC.

Having identified these issues, the Subgroup will work with NHS GGC to seek assurance that they have already been resolved or that action is being taken to resolve them; compare systems, processes and governance with national standards, and make recommendations for improvement and good practice as well as lessons learned across NHS Scotland.

Deliverables

The Deliverables for the Communication and Engagement Subgroup are:

- a prioritised description of communication and information to be provided to families, with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered);
- development of a strategic Communication and Engagement Plan with a person-centred approach as key. This should link to and be informed by consideration of existing person-centred care and engagement work within the Board, to ensure continued strong links between families and NHS GGC. Specific enhancements and improvement proposals should also be clearly identified and should consider how the proposals from parent representatives on an approach that identifies and supports the delivery of personalised actions through the 'PACT' proposal can inform further work;
- a description of findings following a review of materials, policies and procedures in respect of existing practices with regards to communication, engagement and decision-making arising from corporate and operational communication and engagement, linked to infection prevention and control and related issues. This will include consideration of organisational duty of candour, significant clinical incident reviews, supported access to medical records (including engagement, involvement and provision of information to families in relation to these processes); and
- a description of findings and recommendations to: (a) NHS GGC; (b) Health Protection Scotland; (c) NHS Scotland; and (d) Scottish Government on learning to support any required changes and improvements for communication and public engagement relating to the matters considered by the Subgroup.

Governance

The Communication and Engagement Subgroup will be chaired by Professor Craig White, and will report to the Oversight Board. The Oversight Board is chaired by the Chief Nursing Officer, Scottish Government and reports to the Cabinet Secretary for Health and Sport. Members and those present at Subgroup meetings should ensure that they circulate information about the work of the Subgroup to colleagues and networks with an interest, contribution and perspective that can inform the work to be undertaken. It has been agreed

that this must include clinical/care staff in relevant operational services, as well as senior management/corporate staff in NHS GGC.

Membership

Member	Job Title
Professor Craig White (Chair)	Divisional Clinical Lead, Healthcare Quality and Improvement Directorate, Scottish Government
Lynsey Cleland	Director of Community Engagement, Healthcare Improvement Scotland
Andrew Moore	Head of Excellence in Care, Healthcare Improvement Scotland
Professor Angela Wallace	Nursing Director, NHS Forth Valley
Jane Duncan	Director of Communications, NHS Tayside
Professor John Cuddihy	Families representative
Alfie Rawson	Families representative (until March 2020)
Suzanne Hart	Communications, Scottish Government
Phil Raines	Chief Nursing Officer's Directorate (CNOD), Scottish Government
Calum Henderson (Secretariat)	CNOD, Scottish Government

In addition to these members, other attendees may be present at meetings based on agenda items, for example: Chair of Infection Prevention and Control and Governance subgroup; relevant Directors and senior staff from NHS GGC and communication staff from Scottish Government.

Stakeholders

The Subgroup recognise that a broad range of stakeholder groups have an interest in their work, and will seek to ensure their views are represented and considered. These stakeholders include:

- patients and their families;
- the general public;
- the Scottish Parliament;
- Scottish Government, particularly the Health and Social Care Management Board;
- the staff of NHS GGC, Trade Unions and professional bodies; and
- the senior leadership team of NHS GGC and the Board.

Annex B: Peer Review Terms of Reference

Purpose and Governance

The Infection Prevention and Control Governance (IPCG) Subgroup of the NHS GGC Scottish Government Oversight Board has examined an array of documentation from NHS GGC which outlines the form and function of governance regarding IPC. The purpose of the Peer Review is to understand how these systems are operationalised at all levels of the organisation.

The Peer Review group will report to the IPCG Subgroup which itself reports directly into the Oversight Board, Chaired by the Chief Nursing Officer, Professor Fiona McQueen.

Approach

The Peer Review will take a values-based approach in line with the National Performance Framework (NPF) and the values of NHS Scotland (NHS Scotland).

The focus of the Peer Review is to gain an understanding of how IPC systems and processes are embedded and also establish how the governance framework which supports these systems and processes is operationalised.

It is important to state that ensuring that IPC systems and processes are embedded and governed is not the sole responsibility of the IPC Team. It requires support and collaboration at all levels of the organisation; across specialties, teams and directorates both at Board and also at national level. Therefore, the Peer Review plans to liaise with many other disciplines where patient safety associated with IPC is key. This liaison will include directors and managers, facilities and estates, senior charge nurses as well as local IPC teams.

Objectives

The Peer Review objectives are to:

- review how the IPC governance framework provided and described by NHS GGC at the IPCG Subgroup is operationalised across the system; and
- determine how national policy has been implemented within NHS GGC; identifying areas where this has carried out in line with national requirements as well as areas where this could be improved.

Having reviewed the documentation provided by NHS GGC, the Peer Review has identified five areas of focus:

- implementation of HAI-SCRIBE;
- implementation of the National IPC Manual;
- audit and surveillance;

- outbreak and incident investigation (including escalation/de-escalation); and
- water safety.

In Scope

In order to meet these objectives, and with the support of NHS GGC Programme Management Office, the Peer Review team will retrospectively review the relevant (and perhaps supplementary) documentation with the objective of developing a question set. The Peer Review will also review how IPC intelligence and lessons learned are communicated and shared across disciplines, including within the IPC Team.

The Peer Review Team will then meet informally with various stakeholders as described above to gain a deeper understanding of how these systems and processes operate and how key information and lessons learned are communicated locally. This will allow the Team to develop a set of recommendations based on their expert knowledge and skills in the IPC Team and Facilities and Estates.

Out of Scope

As stated in the Terms of Reference for the IPCG Subgroup, the Peer Review Team will not undertake a review of the roles and responsibilities of individual staff members within NHS GGC. However, the Peer Review will review how IPC key information and lessons learned are shared across disciplines, including within the IPC Team.

Governance

The Peer Review Team will report to the IPCG Subgroup, which is chaired by Diane Murray.

Reporting

A report and recommendations will be developed by the Peer Review Team and submitted through the IPCG Subgroup to the Oversight Board.

Peer Review Team Members

Member	Job Title	Review area
Frances Lafferty	Senior IPC Nurse, NHS Ayrshire and Arran	Implementation of HAI-SCRIBE
Lesley Shepherd	Professional Nurse Advisor, HCAI/AMR, Scottish Government	Audit Surveillance National IPC Manual

Annex C: Stages of Escalation in NHS Scotland Board Performance Escalation Framework

Stage	Description	Response
Stage 1	Steady state 'on-plan' and normal reporting	Surveillance through published statistics and scheduled engagement of ARs/MYRs
Stage 2	Some variation from plan; possible delivery risk if no action	Local Recovery Plan – advice and support tailored if necessary. Increased surveillance and monitoring Scottish Government. SG Directors aware.
Stage 3	Significant variation from plan; risks materialising; tailored support required	Formal Recovery Plan agreed with Scottish Government. Milestones and responsibilities clear. External expert support. Relevant SG Directors engaged with CEO and top team. The Chief Executive of NHS Scotland is aware.
Stage 4	Significant risks to delivery, quality, financial performance or safety; senior level external support required	Transformation team reporting to the Chief Executive of NHS Scotland.
Stage 5	Organisational structure/configuration unable to deliver effective care.	Ministerial powers of Intervention.

Annex D: Key success Indicators of the Oversight Board

Outcome	Action	Example of evidence
Infection Prevention and Control and Clinical Governance		
There is appropriate governance for infection prevention and control (IPC) in place to provide assurance on the safe, effective and person-centred delivery of care and increase public confidence.	Carry out a system wide review of current IPC systems and processes and associated governance scheme of delegation and escalation mechanisms against relevant national standards and guidance.	• Confirmation of current/sustainable effective governance with respect to: HAIRT Reports; Clinical Governance Committee and Audit and Risk Committee Reports; AOP and Corporate Objectives and Performance Reports; IPC Inspection and Escalation Reports; IPC Audit Reports and Action Plans; relevant Antimicrobial Management/ Infection Control/ Decontamination/ Water Safety/ Education and Training/ Surveillance/ Outbreak Preparedness and Management/ Audits/ Policy and Procedures/ Inspection and Action Plans/ IPC Escalation Reports/ SBARs/ Research and Development and Voluntary Action Plan Updates; and IPC Risks. • Active action plans to address recommendations/action on relevant HPS/ HEI/ Internal reports since 2015 with clear timelines, monitoring, action responsibility and appropriate oversight.
	Determine if there are any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to IPC risk management, audit, performance, compliance and assurance.	• Report setting out gaps in national standards/guidance and provision of NHS GGC action plan to address issues and monitoring arrangements for action plan. • Report setting out wider learning with regards to IPC risk management, audit, performance, compliance and assurance for consideration by DG Health and Social Care, SG Ministers, and NHS Chairs and NHS Chief Executives fora (as part of wider Oversight Board reporting).

Outcome	Action	Example of evidence
The current approaches that are in place to mitigate avoidable harms, with respect to infection prevention and control, are sufficient to deliver safe, effective and person-centred care.	Conduct a detailed review of relevant individual instances of infection and identify actions on individual cases and systemic improvements.	• Clear methodology for identifying and undertaking review of all relevant cases, validated by external experts. • Identification of general issues relating to the IPC governance issues and provision of NHS GGC action plan to address issues and monitoring arrangements for action plan. • Identification of individual issues relating to specific cases and NHS GGC action plan to communicate and engage with relevant families/patients and monitoring arrangements for action plan.
	Ensure that the physical environment to the relevant wards in QEUH and RHC support the delivery of safe, effective and person-centred care with respect IPC, particularly in the delivery of any refurbishments/physical improvements.	• Action plan setting out identification of key issues in Ward 6A in QEUH and implementation of how they have been dealt with. • Assessment setting out completion of refurbishment works in Wards 2A/2B in RHC and how identified issues were addressed. • Confirmation of action plan and assessment above by HPS.
	Determine if there are any gaps when mapped against national standards and guidance and, if so, identify areas for improvement and shared learning with respect to operational delivery of IPC, including staffing/ resourcing, minimum skills and joint working between relevant units.	• Evidence of full implementation of mandatory national HCAI and AMR policy requirements as set out in DL (2019) 23. • NHS GGC action plan to identify staffing/ resourcing gaps in IPC operations with respect to putting in place policy requirements in DL (2019) 23, address the identified gaps with clear actions/ timetables and monitoring arrangements for delivery.
Outcome	**Action**	**Example of evidence**
Communication and Engagement		
Families and children and young people within the haemato-oncology service receive relevant information and are engaged with in a manner that reflects the values of NHS Scotland (NHSS) in full.	Prioritise communication and information provided to families and patients with a focus on respect and transparency (with an initial focus on ensuring that all outstanding patient and family questions raised are answered).	• Compilation of outstanding questions by families and publication of responses on NHS GGC website. • Published process for responding to questions in future as part of NHS GGC Communication strategy. • All additions/revisions/updates to questions previously answered have been made as soon as additional information has been received and/or reviewed.

Families and children and young people within the haemato-oncology service are treated with respect to their rights to information and participation in a culture reflecting the values of the NHSS in full.	Develop and implement a strategic NHS GGC Communication strategy with a person-centred approach, including a clear Executive Lead for implementing and monitoring.	• Publication of relevant NHS GGC Communication strategy with evidence of co-production with families. • Identification of Executive Lead to implement strategy with monitoring arrangements and measures of implementation and measures of effectiveness in place.
	Review key materials, policies and procedures in respect of existing practices with regards to communication, engagement and decision-making regarding consideration of the organisational duty of candour similar reviews (including engagement, involvement and provision of information to families in relation to these processes), and identification of any national learning/ lessons learnt.	• Report setting out gaps in compliance, opportunities for improvement, recommendations for action and provision of NHS GGC action plan to address issues and monitoring arrangements for action plan. • Identification of individual issues relating to specific cases and NHS GGC action plan to communicate and engage with relevant families/patients. • Reporting setting out wider learning with regards to organisational duty of candour and other review processes and management of IPC activities for consideration by DG Health and Social Care, SG Ministers, and NHS Chairs and NHS Chief Executives fora (as part of wider Oversight Board reporting). • Clear description of how communication, engagement, information provision and support dimensions of Oversight Board case reviews will integrate family involvement and engagement in accordance with best practice case reviews and individual family preferences.

NHSGGC (M) 21/03
MINUTES: 26 - 45

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
NHS Greater Glasgow and Clyde Board
Held on Tuesday 27th April 2021, at 9.30 am
Via MS Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Cllr Sheila Mechan
Cllr Caroline Bamforth	Ms Ketki Miles
Ms Susan Brimelow OBE	Mr Allan MacLeod
Mr Simon Carr	Cllr Jonathan McColl
Cllr Jim Clocherty	Ms Dorothy McErlean
Mr Alan Cowan	Ms Anne-Marie Monaghan
Professor Linda de Caestecker	Cllr Iain Nicolson
Ms Jacqueline Forbes	Mr Ian Ritchie
Mrs Jane Grant	Mr Francis Shennan
Cllr Mhairi Hunter	Ms Paula Speirs
Mrs Margaret Kerr	Ms Rona Sweeney
Ms Amina Khan	Mrs Audrey Thompson
Mr John Matthews OBE	Ms Flavia Tudoreanu
Dr Margaret McGuire	Mr Charles Vincent
Professor Iain McInnes	Mr Mark White

IN ATTENDANCE

Mr Callum Alexander	..	Business Manager
Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Ms Gillian Duncan	..	Secretariat (Minutes)
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Mr William Edwards	..	Director of eHealth
Mr Graeme Forrester	..	Deputy Head of Board Administration
Ms Lorna Kelly	..	Director of Primary Care
Ms Louise Long	..	Chief Officer, Inverclyde HSCP
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susan Manion	..	Interim Director of GP Out of Hours
Mrs Geraldine Mathew	..	Secretariat Manager
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Julie Murray	..	Chief Officer, East Renfrewshire HSCP
Ms Laura Reid	..	Azets
Ms Caroline Sinclair	..	Interim Chief Officer, East Dunbartonshire HSCP
Mr Tom Steele	..	Director of Estates and Facilities
Ms Shiona Strachan	..	Interim Chief Officer, Renfrewshire HSCP
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
26.	**WELCOME AND APOLOGIES**		
	Professor John Brown, Chair, welcomed those present to the meeting and wished Ramadan Mubarak to all of the Muslim community and all of the Muslim members of staff observing the holy month of Ramadan. The meeting combined Members joining via video conferencing and a socially distanced gathering of some members within the Board Room of JB Russell House. Professor Brown reminded Members of the appropriate etiquette during the online discussion and welcomed the members of public who were joining the Board meeting as observers. Professor Brown introduced Professor Iain McInnes who had joined the Board on 1st April 2021 as the new Stakeholder Member for the University of Glasgow. He advised that Professor McInnes was replacing Professor Dame Anna Dominiczak who had stepped down from this post. Dame Anna is currently on secondment to the UK Government Department of Health and Social Care (DHSC) as Director of Laboratories, NHS Test and Trace. Professor Brown personally thanked Dame Anna for her extensive contribution and commitment to NHSGGC in recent years and on behalf of the Board, wished her the very best for her new endeavours. Professor Brown also advised that there would be a further two new Non Executive Board Members joining the Board on 1st June 2021, Dr Paul Ryan and Mrs Michelle Wailes. No Member apologies were received. **NOTED**		
27.	**DECLARATION(S) OF INTEREST(S)**		
	Professor Brown invited Members to declare any interests in any of the items being discussed. Professor Brown also reminded members of the requirement to keep their details on the Register of Interest up to date and asked for any changes to be notified to the Secretariat team. Mr Charles Vincent declared an interest in Item 8 - Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC). A member of Mr Vincent's family had previously been involved in discussions around the infection prevention and control systems at the QEUH campus. Having discussed this with the Board Chair in advance of the meeting, it was agreed that this was not significant enough to affect any influence in the consideration of today's agenda item and Mr Vincent would be welcome to take part in the discussion.		

	Mr Francis Shennan also declared an interest in Item 8 - Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC). Mr Shennan had previously made a claim for damage to his property against Multiplex, the company coincidentally responsible for the construction of the QEUH. As this was not considered significant, Mr Shennan would be welcome to take part in the discussion. **NOTED**		
28.	**MINUTES OF PREVIOUS MEETING**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on 23 February 2021 [Paper No. NHSGGC (M) 21/02]. It was noted that under Item 13 – NHSGGC Remobilisation Plan Update [Minute No.22], there had been a discussion about the future of the Moving Forward Together Steering Group and the impact of the Remobilisation Plan on the Moving Forward Together programme that had not been referenced in the minute. Professor Brown acknowledged that this had been overtaken by events but and advised that Mrs Grant had provided assurance that the relationship between the Remobilisation Plan and the Moving Forward Together programme was being considered by the Corporate Management Team and the Board minute would be amended to clarify this point. On the motion of Ms Audrey Thompson, seconded by Ms Paula Speirs, the minute of the meeting was approved and accepted as an accurate record subject to the amendment noted above. **APPROVED**		Ms Vanhegan
29.	**MATTERS ARISING**		
	BOARD ROLLING ACTION LIST		
	The Board considered the Rolling Action List of the NHSGGC Board [Paper No. 21/10]. Professor Brown asked the Board if they had any matters arising that they wished to raise. No matters were raised and Members agreed to the closure of the three actions noted on the Rolling Action List. The Board were content to note the Rolling Action List. **NOTED**		

30.	**CHAIR'S REPORT**		
	Professor Brown advised that since the last Board meeting, he had attended meetings of the Audit and Risk Committee, the Finance, Planning and Performance Committee and the Staff Governance Committee and the Standing Committee Chair's reports for these were included with the papers for today's meeting, Professor Brown advised that regular briefing sessions for MPs and MSPs had taken place before the pre-election period. These mainly focused on COVID-19 and the vaccination programme. He also advised that the NHS Board Chairs had met and the focus of these discussions had been the response of NHS Scotland to the COVID-19 pandemic. A separate meeting of the West of Scotland Board Chairs had also taken place and a joint meeting of NHS Board Chairs and Chief Executives had also been held to discuss the pandemic and the emerging plans for remobilisation, recovery and reform of the NHS. Professor Brown advised that the Glasgow Health Sciences Partnership Oversight Board had met and an update on the work of this group would be brought to a future Board meeting. Professor Brown advised the Glasgow Centre for Population Health management board had met and there would be further discussions about the future direction of the Centre's work, as the Scottish Government's approach to improving population and wellbeing continues to develop following the Scottish Parliament election. Professor Brown continues to chair the NHS Scotland Global Citizenship Advisory Board and the NHS Scotland Corporate Governance Steering Group and had attended a variety of meetings with key stakeholders to take these two important initiatives forward. Professor Brown had a number of discussions with the Royal College of Physicians of Edinburgh and their paper reviewing the governance of the Board would be discussed at Item 16 on today's agenda. The Board were content to note the Chair's Update. **NOTED**		Ms Vanhegan
31.	**CHIEF EXECUTIVE'S REPORT**		
	Mrs Grant advised that significant work was ongoing in relation to the Oversight Board and Casenote Review and more detail on that would be provided during discussion of Item 8 on today's agenda.		

	She also advised that she had recently attended a clinical governance symposium which discussed diagnostics during the pandemic that she had found very interesting. Mrs Grant had chaired a meeting of the Regional Cancer Advisory Group which had mainly focused on recovery issues. There had also been a number of national and regional NHS Chief Executive meetings which had focused on the ongoing response to the COVID-19 pandemic and work on recovery. Mrs Grant and Professor de Caestecker had met with the Local Authority Chief Executives to discuss the vaccination programme and longer term planning, for example, the future of Test and Protect. Mrs Grant advised that the third Remobilisation Plan had been submitted to the Scottish Government and was awaiting their response. She stressed that the need for recovery had been balanced with the recognition that staff needed time to recuperate. The Board were content to note the Chief Executive's update. **NOTED**		
32.	**PATIENT STORY**		
	Professor Brown said that as usual the meeting would start with a presentation on service delivery which served to remind Members that everything we do should be viewed from the perspective of patients and service users. He asked Dr McGuire, Nurse Director, to introduce the Patient Story. Dr McGuire provided a brief presentation entitled "Care Home Residents - Meaningful Contact with those Who Matter to Them" which shared the experience of two care home residents in Inverclyde during a period when indoor visiting had been briefly reintroduced prior to Christmas 2020. Professor Brown thanked Dr McGuire for the presentation and said that it was a great example of how people are working collaboratively to provide a quality health service across the system and that this was clearly an approach that we would want to maintain and develop going forward. Professor Brown also extended his personal thanks to Dr McGuire for her leadership in ensuring Care Homes had received the required support during the COVID-19 pandemic.		

33.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update [Paper No. 21/11] presented by Mrs Grant, Chief Executive. Mrs Grant described the final Oversight Board and Case Note Review papers that had been published on 22nd March 2021. Mrs Grant said that NHSGGC acknowledged that there were lessons to be learned and recognised the impact that these issues have had on patients, their families and our staff. Mrs Grant reiterated the Board's sincere apologies for the distress caused. Mrs Grant advised that an Action Plan was being finalised that would formally address the recommendations from the reports, including setting out a governance framework and a timetable for completion. She said that a meeting was scheduled to take place in June 2021 with the Scottish Government to agree the Action Plan and provide assurance that the recommendations were being addressed. Mrs Grant advised that the Board currently remained on Level 4 of the NHS Scotland Performance Management Framework in relation to infection prevention, management and control at the QEUH and the RHC and the associated communication and public engagement issues. Mrs Grant advised that work continued to review the actions arising from the Independent Review report and this was being monitored by the Executive Team through the Gold Command arrangements. She advised that all recommendations and actions relevant to NHSGGC had either been completed or were underway. She said that work would continue on this in parallel with the Action Plans relating to the Oversight Board and Case Note Review. Mrs Grant advised that significant work was also underway in relation to the Scottish Hospitals Public Inquiry, the Board's legal proceedings against the main contractor to the hospital project, and the response to the Health and Safety Executive (HSE) Improvement Notice. Professor Brown thanked Mrs Grant for the update and said that he recognised that there was a considerable amount of work that continued to be undertaken in responding to what had been an unprecedented and challenging situation. He acknowledged that while there was still work to be undertaken, the Board should be assured that appropriate action was being taken by the Chief Executive and the executive leadership team to respond to the situation.		

	In response to a question about the HSE Improvement Notice in relation to the ventilation system for Ward 4C, Mrs Grant provided assurance that this was considered a safe clinical environment and as set out in the Board paper, NHSGGC was appealing against the HSE Improvement Notice. In response to a comment about ensuring that the totality of risks was understood, Professor Brown advised that work was ongoing with the Board's internal auditors to review the risk management system. In response to a query about providing public reassurance that NHSGGC was responding to the recommendations set out in the reports, Ms Sandra Bustillo, Director of Communications and Public Engagement, advised that there was considerable communications work taking place in conjunction with the Scottish Government to ensure a coordinated response. She advised that media statements were shared with Board Members and the Involving People Network which included MPs, MSPs and Elected Members. She said it was important to now build on this and provide reassurance that our hospitals were safe and that the quality of care continued to be of a very high standard. Professor Brown agreed and thanked the Communications Team for working to get that message into the public domain. In summary, Professor Brown said that an update on progress with the Action Plan would come to the Finance, Planning & Performance Committee Board and this would include details on where the oversight and governance for each action would The Board were content to note the update. **NOTED**		Mrs Grant
34.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 21/12] presented by Professor Linda de Caestecker, Director of Public Health. Professor de Caestecker provided an overview of the current position in respect of the NHSGGC response to the COVID-19 pandemic. She advised that there had been a significant reduction both in the number of COVID-19 cases in the community and in the number of patients in hospital. However, she cautioned that it was important to remain vigilant as there was some volatility being seen in the rates which had mainly been attributed to household clusters. Professor de Caestecker was pleased to report that there had been a significant improvement in Care Homes and advised that some visiting for Care Homes and Hospitals had recommenced.		

Professor de Caestecker advised that the expansion of asymptomatic testing continued and this was focusing particularly on areas with the highest rates of infection.

Professor de Caestecker also advised that the vaccination programme was continuing at pace and the 40-50 age group were currently being invited for vaccination. It was expected that all first doses would be completed by the end of July 2021. She said that there was no guidance on booster vaccinations as yet but assured Members that there was enough flexibility in the system to respond to this in the future.

In response to a query about Lateral Flow Testing, Professor de Caestecker advised that people were being encouraged to take part in asymptomatic testing either using home test kits or by attending asymptomatic test sites in the community. Anyone recording a positive Lateral Flow Test result would then be asked to attend for a PCR test to confirm this. Professor de Caestecker emphasised that it was important that people taking Lateral Flow Tests documented their results using the national tool.

A question was asked about ensuring that people in the under 30 age category could be confident about receiving the vaccine. Professor de Caestecker acknowledged that there had been concerns raised recently around the safety of the Astra Zeneca vaccine in this age group but said that the risk of developing blood clots was very low and it was important to encourage younger people to be vaccinated. She said it was not possible at present to give a choice of vaccines in the vaccination centres but people in that age group should attend their appointments and their concerns would be discussed on an individual basis. Dedicated clinics with alternative vaccinations would be arranged for people in this age group who hadn't yet been appointed.

There was discussion about at what point COVID-19 should stop being managed as an incident and become part of the regular business of NHSGGC. Mrs Grant reassured the Board that this was already the case and NHSGGC was also focused on remobilisation. She advised that discussions were also taking place nationally with NHS and Local Authority Chief Executives to look at the health inequalities and prevention agenda. However, she said there was still a considerable amount of work being done to ensure we were prepared to respond to any spikes in infection, including retaining the green pathways and infection control processes. She added that prevention should be at the top of everyone's priority and Test and Protect staff would remain in place until at least 2022.

In response to a question around delayed discharges, Dr McGuire advised that the number of delayed discharges directly linked to COVID-19 was low, although she acknowledged that the delayed

	discharge rate remained high overall, and much of this was due to the Equality and Human Rights Commission ruling in relation to Adults with Incapacity. Dr McGuire advised that work was continuing to minimise delayed discharges. In terms of staff vaccination, Professor de Caestecker advised that on the whole uptake was very good. She said there were no capacity issues, although she acknowledged that some people had received their vaccination date later than expected as appointments had to be balanced with supplies. She advised that work was ongoing with Local Authority colleagues and our Communications Team to provide reassurance to staff. A question was asked about the Community Assessment Centres and at what stage their contribution would be reassessed with the potential to reassign the resources. Ms Susanne Millar, Chief Officer of Glasgow City HSCP, advised that these were continually under review and an Operational Group met weekly. Dr Jennifer Armstrong, Medical Director, added that modelling was undertaken every week to provide clinical advice to that Group on how best to match capacity and demand. The Board asked that the contribution that Glasgow had made to research and development during the COVID-19 pandemic was recognised, particularly the work of the research teams led by Professor Julie Brittenden, Director of Research and Development. In response to a query about recognising individual staff for their support during the pandemic, Professor Brown said that as there were significant numbers of staff across NHSGGC who had made a considerable contribution to the response to the pandemic, it was not possible to single out specific staff. He said that a personal message and a badge had been send out to all staff as a token of the Board's appreciation of the effort everyone had made over the last year. There was also a sustained focus on staff wellbeing to ensure all staff were well supported. Professor Brown thanked Professor de Caestecker and the Board Members for a full discussion. On behalf of the Board he recorded his thanks to Professor de Caestecker for leading the NHSGGC response to the COVID-19 pandemic. Professor Brown also asked for the Board's thanks to be recorded to everyone who had been a part of NHSGGC's impressive response to the pandemic. The Board were content to note the COVID-19 update **NOTED**		

35.	**NHSGGC PERFORMANCE UPDATE**		
	The Board considered the paper 'NHSGGC Performance Update' [Paper No. 21/13] presented by Mr Mark White, Director of Finance. Mr White advised that the paper covered the whole of the financial year 2020/21 and outlined the current performance against each of the measures in the second phase Remobilisation Plan and proposed improvement actions. Mr White advised that, as at 31st March 2021, of the 14 key performance indicators, 10 had been achieved, one was amber and three were red. Mr White advised that the phase three Remobilisation Plan had been submitted to the Scottish Government and feedback on that was awaited. In response to a query about attendances at Emergency Departments (EDs), Mr Jonathan Best, Chief Operating Officer, advised that the performance was steady but the attendance levels were not back to pre-COVID levels. He noted that there were a number of initiatives underway including the Flow Navigation Centre and work with the HSCPs to signpost people in the community to call 111. Professor Brown was pleased to note that recent ED performance was one of the best in Scotland. In response to a query about Board scrutiny of performance, Mrs Grant advised that the phase three Remobilisation Plan would set out targets and timelines. In response to a question about the difference between the phase 2 and phase 3 Remobilisation Plans, Mrs Grant advised that the new plan was different but the granularity was still being discussed with the Scottish Government and there was a recognition that staff wellbeing was incredibly important. A full report would come to the Board in June. There was a discussion on specific improvements and Professor Brown advised that the Acute Services Committee was the appropriate route for these detailed discussions. However, he advised that Azets were working on the flow of information to the governance committees and Board Members would be able to access this information. Professor Brown recorded his thanks to all staff for delivering the level of performance in the difficult circumstances caused by COVID-19. The Board were content to note the Performance Summary. **NOTED**		Mrs Grant

36.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Report' [Paper No. 21/14] presented by Professor Angela Wallace, Executive Director of Infection Prevention and Control. Professor Wallace provided an overview of the key elements of the report. She noted that sustained performance improvement over time was being seen, particularly in AOP. She said that the March HAIRT was in the process of being finalised but was pleased to advise that the same level of performance was being seen. Professor Wallace advised that work was ongoing to ensure the data was as real time as possible and that the work on creating a dashboard with Mr William Edwards, Director of eHealth, and his team was nearing completion. Professor Wallace advised that the HEI had undertaken an unannounced inspection of the Vale of Leven Hospital and congratulated the team on their achievement. In terms of COVID-19, Professor Wallace advised that the ward closures associated with this were very much improved and any incidents were very small. In summary, Professor Wallace assured the Board that work continued across NHSGGC in respect of infection prevention and control and that all incidents highlighted in the report had been addressed and managed. Professor Brown welcomed the update and the sustained performance improvement. He also congratulated staff at the Vale of Level for their positive HEI report and said that COVID numbers give a lot of assurance. In response to a question about when the Board might expect to be de-escalated from Level 4 on the Scottish Government Performance Management scale, Professor Wallace advised that all reports and updates had been shared with the Scottish Government and she been consistent in the message that performance and processes relating to infection control and prevention within NHSGGC were excellent. She said that the whole Executive Team was supportive and her observation was that this was a good system that was consistently responding and improving. Professor Brown thanked Professor Wallace for her insight and for providing assurance that the infection control process was working well to keep our hospitals safe.		

	The Board were content to note the Healthcare Associated Infection Report. **NOTED**		
37.	**NHSGGC FINANCE UPDATE**		
	The Board considered the paper 'NHSGGC Finance Update' [Paper No. 21/15] presented by Mr Mark White, Director of Finance. Mr White advised that the year-end position was being finalised but it was anticipated that the Board would break-even this financial year. Mr White advised that the Board and the HSCPs had received full funding from the Scottish Government for all COVID-19 direct and indirect costs. Mr White acknowledged that there was an increase in the underlying recurring deficit as it had not been possible to fully implement the Financial Improvement Programme in 2020/21 due to COVID-19 but this was now being refreshed for financial year 2021/22 to maximise the level of recurring savings. Professor Brown thanked Mr White for the update and said it was impressive that the Board had managed to achieve its financial targets in the current climate. In response to a question about the impact of COVID-19 on finances going forward, Mr White confirmed that the risk element of COVID-19 would become part of business as usual. He advised that the additional costs generated by COVID-19 had been fully funded in financial year 2020/21 and that the funding for 2021/22 included money to offset additional costs although further scrutiny of these costs was required. The Board was content to note the month 11 revenue position, the month 11 capital position and the position with the Financial Improvement Programme. **NOTED**		
38.	**WORKFORCE STRATEGY 2021-2025**		
	The Board considered the paper 'Workforce Strategy 2021-25" [Paper No. 21/16] presented by Mrs Anne MacPherson, Director of Human Resources and Organisational Development. Professor Brown clarified that this paper was for noting as the Workforce Strategy had previously been delegated to the Staff Governance Committee who had formally approved the Strategy.		

	Mrs MacPherson advised that the original ambition had been to complete the Strategy in 2020 but this had been paused due to COVID-19, however, the events of the last year had also helped augment the health and wellbeing aspect of the Strategy, Mrs MacPherson said that the Workforce Strategy identified NHSGGC's workforce priorities over the next few year and there were four key pillars in the Strategy which captured the key themes identified and reflected the ambitions of NHSGGC as an employer – health and wellbeing; learning; leaders; and, recruitment and retention. Each of these pillars had a number of actions that would be managed through the Corporate Management Team with appropriate updates to the Staff Governance Committee Mrs MacPherson advised that there had been extensive engagement on the Strategy with key stakeholders, including the Corporate Management Team and Partnership Fora. There was discussion about the use of the phrase "extended family" in the foreword and it was agreed that Mrs MacPherson would work with Ms McErlean to consider adopting a different phrase that reflected the same sentiment. In response to a query about measuring outcomes, Mrs MacPherson advised that work was underway to develop key performance indicators against each action where it was possible to measure a tangible outcome. She advised that further staff surveys were planned to gauge whether improvements had been made and iMatter would also be recommencing. Professor Brown asked Mrs MacPherson if it was also possible to build in some benchmarking with other NHS Boards as part of the evaluation process to get an idea of where NHSGGC sat nationally. In response to a question about diversity, Mrs MacPherson emphasised that diversity and inclusivity was embedded in all four pillars and specific areas of focus, such as removing barriers, would emerge through the action plan and the activity. Mrs MacPherson advised there was also significant activity nationally on equalities work. The Board were content to note the Workforce Strategy. **NOTED**		Mrs MacPherson Mrs MacPherson
39.	**STAKEHOLDER COMMUNICATIONS AND ENGAGEMENT STRATEGY – YEAR 1 ACTION PLAN**		
	The Board considered the paper 'Stakeholder Communications and Engagement Strategy – Year 1 Action Plan" [Paper No. 21/17]		

	presented by Ms Sandra Bustillo, Director of Communications and Public Engagement. Mrs Bustillo clarified that the Stakeholder Communications and Engagement Strategy had been approved by the Board in December 2020 and the Board had requested that the Year 1 Action Plan be brought back setting out details of the priorities. Ms Bustillo advised that since December 2020, the Scottish Government have published new guidance "Planning with People" to support the delivery of existing statutory duties for engagement and public involvement and setting out how members of the public can expect to be engaged. There had also been the publication of the QEUH and RHC Oversight Board and Case Note Reviews. The Action Plan addressed these reports as well as the Board's overall strategic communication and engagement aims and set out a number of key priorities against 12 strategic aims. Ms Bustillo advised that the delivery of these actions would be reported to the Corporate Management Team and the appropriate governance committees. In response to a question about ensuring engagement with appropriate stakeholders including Elected Members and Community Councils, Ms Bustillo advised that ongoing communications were being developed with HSCPS, for example, West Dunbartonshire and Inverclyde were helping issue the monthly newsletters for their areas. In response to a query about remobilisation, Ms Bustillo said that there was a national and local focus on ensuring there was a consistent remobilisation message and when the third phase Remobilisation Plan was approved the communication would be open and transparent. The Board agreed that it was important to take responsibility for when things didn't go right and to ensure that communication is honest and upfront. In response to a query about measuring the impact of the Action Plan, Ms Bustillo agreed that this was important and there would be a number of different measures to show this, for example, undertaking a "sentiment analysis" to look at how people viewed NHSGGC and repeating that over time to see how that had changed. The Board were content to approve the Year 1 Action Plan. **APPROVED**		
40.	**IMPLEMENTING THE ACTIVE GOVERNANCE APPROACH**		

	The Board considered the paper 'Implementing the Active Governance Approach" [Paper No. 21/18] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration. Ms Vanhegan advised that this paper described the approach being taken to implement active governance in NHSGGC with the aim of improving corporate governance within the organisation, building on the work described in the October 2020 Board paper. The paper also set out the operational priorities for NHSGGC for the first quarter of 2021/22 Ms Vanhegan asked the Committee to approve the five recommendations set out in the paper. The first recommendation asked the Board to approve the NHSGGC Operational Priorities for the first quarter of 2021/22 set out in Appendix C of the paper. A lead governance Committee had been identified for each priority. The Board was content to approve these. The second recommendation asked the Board to approve the reinstatement of the NHSGGC standing committees from May 2021. The Board was content to approve this and arrangements would be made to reinstate the Committees. The Board also approved recommendation three, the membership and meeting dates of the NHSGGC Board standing committees and Integration Joint Boards for 2021/22 which was set out in Appendix D of the paper with an amendment to the date when Mr Simon Carr's term ended. The Board discussed recommendation four, the terms of reference for the NHSGGC Moving Forward Together Advisory Group. Professor Brown said that it was not intended to create another layer of governance. This Group would give non-executive advice and support to the executive leadership team as they developed proposals for the NHSGGC longer term transformational change programme but decisions on the adoption and implementation of changes to current service delivery models would continue be made through existing governance structures. This was approved subject to the amendment making it clear that this was an advisory role and a date for the first meeting would be set. The first meeting would focus on how this group will support the Programme Board and Programme Director. The Board discussed the proposed Active Governance programme for 2021/22. Ms Vanhegan advised that each phase ended with a Board meeting so that updates can be provided regularly and there would be a Board paper twice a year.		Ms Vanhegan Ms Vanhegan Ms Vanhegan

	The Board approved the content of the Action Plan and asked the Corporate Management Team to provide a view on the feasibility of the timescales set out in the document. . The Board were content to approve this paper. **APPROVED**		Ms Vanhegan
41.	**RCPE QGC INDEPENDENT REVIEW OF THE GOVERNANCE OF GREATER GLASGOW AND CLYDE NHS BOARD**		
	The Board considered the paper 'RCPE QGC Independent Review of the Governance of Greater Glasgow and Clyde NHS Board" [Paper No. 21/19] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration. Ms Vanhegan said that the paper presented the findings of the Royal College of Physicians of Edinburgh Quality Governance Collaborative' s review of governance within NHSGGC that had been undertaken by Professor Michael Deighan, Director of the Quality Governance Collaborative. Professor Deighan had observed the Board and its Committees over a number of months and made some recommendations on how the Board's effectiveness could be improved which had been included in the Active Governance Programme Plan. A Board Development Session will take place on 27th July 2021 that would include a session with Professor Deighan on this Review that would give Board Members the opportunity to discuss the methodology and content of the review with Professor Deighan in more detail. The Development Session would also include a presentation from NHS Education for Scotland (NES) on Active Governance and a session with Azets on risk management focussing on reviewing the Board's risk appetite. The Board were content to note the paper. **NOTED**		
42.	**WHISTLEBLOWING UPDATE**		
a)	**Whistleblowing Review**		
	The Board considered the paper 'Whistleblowing Review" [Paper No. 21/20] presented by Mr Charles Vincent, Whistleblowing Champion. Mr Vincent had led the Review with the professional support of Mr Kenneth Small, former Director of Human Resources at NHS Lanarkshire.		

	Before discussing the paper, Professor Brown invited the Co-Chairs of the Staff Governance Committee, Ms Dorothy McErlean and Mr Alan Cowan, to share the views of the Committee on the Whistleblowing Review. Mr Cowan advised that there had been strong scrutiny and oversight of the process by the Staff Governance Committee throughout the review. He advised that a special meeting of the Staff Governance Committee had been held on 15th April 2021 to receive the Whistleblowing Review and the Committee had been content to note the Review. Mr Vincent said the main focus of the review was to make the experience of whistleblowing better and more supportive for everyone involved. He advised that as well as the Staff Governance Committee, he had also worked closely with the Executive Team to ensure the recommendations were implementable. The Review had identified eight recommendations, one of which had previously been approved as an interim recommendation by the Staff Governance Committee in November 2020. Professor Brown thanked everyone who had been involved in the Review as well as the Staff Governance Committee for their overview of the process. The Board were content to note the findings of the Whistleblowing Review and approve the recommendations made. **NOTED**		
b)	**Update on Whistleblowing Standards**		
	The Board considered the paper 'Update on Whistleblowing Standards" [Paper No. 21/21] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration. Ms Vanhegan advised that the new National Whistleblowing Standard came into effect on 1st April 2021 and in preparation for this a Working established in November 2020 to develop an Action Plan and User Guide to support the launch and implementation of the new Standard. She advised that the User Guide picked up a number of the recommendations set out in the Whistleblowing Review [Paper No. 21/20]. Ms Vanhegan advised that Action Plan had been Considered by the Corporate Management Team and the Working Group would continue to meet and oversee progress. Professor Brown invited Mr Vincent to share his view on the paper as Whistleblowing Champion. Mr Vincent confirmed that this had met his expectations and he was assured that everything was in place to meet the new Standards in NHSGGC, although he acknowledged that there was still some work required with primary care and independent contractors. Ms Vanhegan advised that workshops		Ms Vanhegan

	were being arranged with key contractors and she would report back on the outcome of that process. The Board were content to note the update on Whistleblowing Standards. **NOTED**		
43.	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**FINANCE, PLANNING AND PERFORMANCE COMMITTEE**		
	The Board were content to note the Chairs Report of the Finance, Planning and Performance Committee held on 30th March 2021 [Paper No. 21/22]. **NOTED**		
b)	**AUDIT AND RISK COMMITTEE**		
	The Board were content to note the Chairs Report of the Audit and Risk Committee held on 16th March 2021 [Paper No. 21/23]. Mr MacLeod asked the Board to note the timetable for approval of this year's Annual Accounts and consider rescheduling the Audit and Risk Committee planned for 22nd June 2021. The timings were still being finalised but it was agreed that a special Board meeting would be arranged in early September to approve the Annual Accounts and Board Members would be advised of the date at the earliest opportunity. **NOTED**		Ms Vanhegan
c)	**STAFF GOVERNANCE COMMITTEE**		
	The Board were content to note the Chairs Report of the Staff Governance Committee held on 15th April 2021 [Paper No. 21/24]. **NOTED**		
d)	**AREA CLINICAL FORUM**		
	The Board were content to note the Chairs Report of the Area Clinical Forum meeting held on 8th April 2021 [Paper No. 21/25]. **NOTED**		

	The Board were content to note the minutes of the Area Clinical Forum meeting held on 11th February 2021 [Paper No. ACF(M) 21/01]. **NOTED**		
44.	**AOCB**		
	There were no other items of business raised. Professor Brown closed the meeting by thanking the Board Members for a comprehensive discussion. He also offered his thanks to the Executive Team for producing the suite of Board papers and for all the support they provided to the Board.		
45.	**DATE OF NEXT MEETING**		
	The next meeting would be held on Tuesday 29th June 2021, 09:30am, via MS Teams.		

NHS Greater Glasgow & Clyde	**Paper No. 21/11**
Meeting:	**NHSGGC Board**
Date of Meeting:	**27th April 2021**
Purpose of Paper:	**For Noting**
Classification:	**Board Official**
Sponsoring Director:	**Chief Executive**

Paper Title

Queen Elizabeth University Hospital and Royal Hospital for Children Update

Recommendation

The Board is asked to note the Queen Elizabeth University Hospital and Royal Hospital for Children - Update

Purpose of Paper

The purpose of the paper is to update the Board on the overall position in respect of the NHS Greater Glasgow and Clyde (GGC) response to the current issues associated with the QEUH and RHC.

Key issues to be considered

This paper considers some key ongoing issues in respect to the series of independent reviews of the QEUH and RHC sites, specifically:

- Oversight Board and Casenote Review publications
- Progress with the Independent Review
- Current position with regard to:
    - The Scottish Hospitals Public Inquiry
    - Legal Proceedings
    - HSE Investigation

Any Patient Safety /Patient Experience Issues

Ensuring patient safety and the ongoing provision of high quality care are central to our response to the independent reviews and the actions associated with them.

Any Financial Implications from this Paper

There are likely to be financial implications as part of our programme of work based on the recommendations of the independent reviews which will be considered as the action plans are progressed.

Any Staffing Implications from this Paper

There are likely to be staffing implications as part of our programme of work based on the recommendations of the independent reviews which will be considered as the action plans are progressed.

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

Better Health

Author:

Jane Grant, Chief Executive

Tel No: [redacted]

Date 19/04/2021

NHS GREATER GLASGOW AND CLYDE

Queen Elizabeth University Hospital and Royal Hospital for Children Update

NHS Board Update 27th April 2021

1. INTRODUCTION

1.1 NHS Greater Glasgow and Clyde (NHSGGC) remains on Level 4 of the NHS Scotland Performance Management Framework in respect of on-going issues around the systems, processes and governance in relation to infection prevention, management and control at the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC) and the associated communication and public engagement issues.

1.2 As part of the escalation process, an Oversight Board was established, chaired by Professor Fiona McQueen, with three sub groups reporting to it, namely Infection Prevention and Control Governance, Communication and Engagement and a Technical group. NHSGGC has worked closely with the Scottish Government team throughout, providing significant amounts of evidence over the months to the sub groups, reviewing and commenting on draft reports.

1.3 On 8th December 2020 the Finance Planning and Performance Committee received a presentation outlining the findings of the draft Interim Oversight Board Report with the Interim Oversight Board Report being published on 21st December 2020.

1.4 Two further reports have now been published in relation to these issues - the final Oversight Board report and the Casenote Review. These reports were published on 22nd March 2021, with families receiving a copy of the Casenote Review in advance of its publication.

1.5 NHSGGC would again wish to apologise sincerely for the distress and concern that these issues have brought to our patients, their families and staff. There is a clear appreciation of the very challenging circumstances that our patients, their families and our staff have had to face during this difficult time and it is essential that we address these reports in a proactive and positive manner to ensure patient safety remains at the heart of our endeavours and that, where improvements are required, we address them swiftly and systematically. It is also essential that we ensure that we have learned from this difficult set of circumstances to minimise the risk to all our patients, in whatever area of NHSGGC they are being treated in the future.

2. OVERSIGHT BOARD REPORT

2.1 The Oversight Board addressed its work through a review of key documents and direct inquiry with colleagues within NHSGGC over many months. This included the examination of NHSGGC internal minutes and papers, specially commissioned papers on individual topics, material provided to the Scottish Government by some NHSGGC clinicians and microbiologists and a number of key external documents.

2.2 The Oversight Board report sought to address 4 questions:

- To what extent can the source of the infections be linked to the environment and what is the current environmental risk?
- Are IPC functions "fit for purpose" in NHSGGC, not least in light of any environmental risks?
- Is the governance and risk management structure in NHSGGC adequate to pick up and address infection risk?
- Has communication and engagement by NHSGGC been sufficient in addressing the needs of children, young people and families with a continuing relationship with the Health Board in the context of the infection incidents?

2.3 With regard to the first question, the Report indicates that, in the absence of definitive sources, the strong possibility of a link is "undeniable". The Report outlines that the cases "did not necessarily suggest a pattern at first" and water testing before 2018 did not provide evidence of contamination. However, by 2018, there was significant evidence of a succession of environmental defects and NHSGGC was taking action to address the issues. The "timely, robust and focused" response by NHSGGC to water contamination was commended within the Report.

2.4 The report also states that NHSGGC, national bodies and the Scottish Government lacked a strategic understanding of the complexity of the water contamination and that environmental risks associated with hospitals are now better understood overall, not least through the efforts of NHSGGC, which provide a platform for further learning and improvement in the future.

2.5 With regard to the current environmental risk, the report states "Given the water testing results, the chemical dosing system appears to have proven effective. Whilst unusual environmental bacteria can occur in all healthcare settings, the risk must continue to be monitored, evaluated, mitigated and reported".

2.6 In the section concerning the second question relating to the IPC functions, it is highlighted that the Board was quick to react to individual incidents with clear IPC actions and had the ability to take highly challenging steps, to address any risk to the care and safety of the patients. It indicates that imagination and determination were evident in how specific issues were addressed, especially in 2018, but also states that that the ability to see and act on a wider perspective framed by environmental risks and infection incidents, was not apparent.

2.7 Issues were also raised in relation to the functioning of the Incident Management Team meetings and their short term reactive response was noted. However, it is also stated that a number of more significant decisions, such as the introduction of chemical dosing, were taken and this is recognised as being "exemplary". It is also notes that relationships between the Infection Prevention and Control team and key services, such as Estates and Facilities and, between, and among, microbiologists at the QEUH were fraught and compromised effective working. Significant work has been undertaken since then and the Estates and Facilities interface with the infection control team has been strengthened and is now working in a more effective manner. Considerable work has also been undertaken to address the issues within

microbiology at the hospital and this work is ongoing.

2.8 Again, this section also highlights the significant work undertaken by NHSGGC to address all of the issues.

2.9 In relation to the section on governance and risk, the size and complexity of NHSGGC is outlined as a challenge in ensuring cross-cutting issues are addressed across the whole governance system. It commends the work that has already been put in place to make a number of changes, particularly with regard to the issues within Estates and Facilities, where the appropriate operational governance processes had not been followed in the past.

2.10 Further sections outline the fact that there was good evidence of assurance on the actions being given, but there was less evidence of challenge apparent from the Oversight Board's desk-top examination of the minutes of meetings. The approach to Risk management, specifically the description of risks, was considered to require review, although the Report notes that a different approach to recording risk would not have led to a different course of action to respond to, or mitigate, the risk.

2.11 With regard to communication and engagement, the Report states there was substantial evidence of a compassionate approach to communication by frontline staff but stated that communication at a corporate level was inconsistent and some patients and families considered that questions about episodes of infection were not answered in a timely or informative manner. The Report also states that fuller consideration could have been given to psychological harm in the application of the organisational duty of candour.

2.12 Again, it is noted in this section of the Report that a considerable amount of work has already been done, or is underway, to address these issues.

3. CASENOTE REVIEW

3.1 The Casenote Review was also published on 22nd March 2021. This report was commissioned by the Cabinet Secretary for Health and Sport in January 2020 to be undertaken by a panel of independent experts, led by Professor Mike Stevens, Emeritus Professor of Paediatric Oncology from the University of Bristol.

3.2 The purpose of the Casenote Review was to determine how many children and young people with cancer, leukaemia and other serious conditions were affected by a particular type of serious infection caused by Gram-negative environmental bacteria, from 2015 to 2019; to decide, as far as it is possible to do so, whether the infections were linked to the hospital environment, and to characterise the impact of the infections on the care and outcome of the patients concerned. The Review involved the consideration of the cases of 84 children and young people who fell within the relevant criteria.

3.3 The Review's findings indicate that they were unable to identify evidence that unequivocally provided a definite relationship between any infection episodes and the environment. However, the report also states that 34% of the infections might be, on the balance of probability, reasonably considered to be "Most Likely" linked to the environment. It also provides an assessment on the impact of the infections on the individual patients.

3.4 It is noted that there was an increased likelihood that the infections within the "Most Likely" group occurred in 2018 and that there was significant action taken by the Board at that time, with external support from Health Protection Scotland and the Scottish Government.

3.5 This Review acknowledges the steps taken by the organisation to respond to what was an extremely challenging and complex situation. It commends NHSGGC in a number of areas, including the comprehensive and detailed clinical records kept by the medical and nursing teams and the good communication between the microbiologists and the haematology oncology team in relation to the diagnosis and management of infections. It is also states that communication with patients and their families was generally well documented and of a high standard, despite some patients raising concerns in this respect.

3.6 The Review also commends the significant work undertaken by the Quality Improvement Group established in 2017 to reduce the level of central line associated infection which currently remains low.

3.7 The Review outlined a number of issues where improvement is required, particularly in relation the accuracy, use and availability of data. Concerns were raised about the ability of NHSGGC to obtain a full, and detailed picture of the position with its current processes and data systems. It also documents some concerns about the location and filing of patient records.

3.8 Issues relating to the systematic recording and review of all maintenance activity in clinical areas were raised and the need for accuracy in relation to precise locations/timings for testing and maintenance / repair work was identified. A systematic, fit for purpose, routine, microbiological water sampling and testing system is recommended and is now in place.

3.9 The Review identifies areas where the management of outbreaks required improvement and highlights areas similar to these raised in the Oversight Board report. It recommends rigorous review of all Gram-negative bacteraemia with a multi-professional group reviewing the data.

3.10 Recommendations are also made in relation to the functioning of Incident Management Teams and the need for a revised approach to be developed. The enhanced use of infection prevention and control audits and hand hygiene audits as an integral element of any Incident Management Team process is also recommended.

3.11 A number of recommendations are made in relation to clinical care including issues associated with central venous line care, ongoing audit of the use of antibiotic prophylaxis and additional morbidity and mortality reviews of any patients who have a GNE infection.

4. SUMMARY

4.1 A number of recommendations for NHSGGC and for national implementation are made within both reports. The final Oversight Board report has 18 recommendations, 12 solely for NHSGGC to implement, with 6 for national implementation. The Casenote Review has 43 recommendations over 15 themes with 42 of them for local action, with one recommendation for national action.

4.2 An overall comprehensive action plan to address all the recommendations has been put in place to address the issues. A specific delivery group (Gold Command), chaired by the Chief Executive, has been established to provide updates to the Corporate Management Team and, in turn, to the appropriate governance committee of the NHS Board to ensure focused work is undertaken on all of the recommendations.

4.3 Within the Oversight Board report, 5 of the local recommendations are fully or partially completed, with the remainder underway. Similarly, within the Casenote Review local recommendations, 10 are complete, with the remainder underway or about to commence. This work will be monitored carefully within the internal management processes as described earlier in the paper. Regular progress reports will also be provided to the Scottish Government and the appropriate governance committee of the NHS Board.

4.4 At present, NHSGGC will remain at Level 4 of the escalation framework and discussions have taken place with Scottish Government colleagues to establish an ongoing monitoring process to ensure clarity on their requirements and that continued progress is made.

5. INDEPENDENT REVIEW

5.1 Work continues to review the actions arising from the report of the independent review of infection control concerns at the QEUH and the RHC by Dr Andrew Fraser and Dr Brian Montgomery.

5.2 This is being progressed in accordance with the action planning methodology recommended by the Scottish Government. Progress is being monitored by senior Directors through the Gold Command process as outlined above. All recommendations and actions relevant to NHSGGC are either complete with on-going monitoring or are underway. This work will continue in parallel with the overall action plans relating to the Oversight Board and the Casenote Review to ensure a systematic and aligned approach.

6. SCOTTISH HOSPITALS PUBLIC INQUIRY

6.1 The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. On 19th January 2021 Lord Brodie announced timescales for 2021 and on the 1st February 2021 issued core participants with formal evidence requests focussed on the priorities outlined below:

- Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care.
- Governance and Project Management - as far back as 2002.
- Effects of the issues identified on patients and their families.

6.2 The first formal meeting took place on Thursday 18th March 2021 which was an initial gathering of the legal representatives of core participants, at which Lord Brodie explained the progress of the Inquiry and the programme going forward.

6.3 The first formal hearing of the Inquiry will take place on Tuesday 22nd June 2021. This will be a procedural hearing to confirm arrangements for the first substantive hearings in September 2021.

6.4 The first substantive hearings of the Inquiry will commence on Monday 20th September 2021 and will last for three weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those called upon to give evidence in person at the initial hearings.

6.5 It is likely that the next set of hearings will be scheduled for late 2021 /early 2022, with a procedural hearing ahead of that time. Further details of what will be covered and the programme for the hearings will be published in due course, however it has been indicated that the initial focus will be on the inquiry into the Royal Hospital for Children and Young People in Edinburgh.

6.7 We continue to work with the dedicated team from the Central Legal Office on all issues connected to the QEUH/RHC. A number of meetings have been held with the Inquiry Team Solicitors with documents now being transferred as requested in a coordinated manner.

6.8 It is evident that there is significant cross over with the issues associated with the Inquiry and those of the Legal Claim and hence oversight of both elements is critical moving forward. The Programme Management Office (PMO) resources have been increased with a single Project Team being created to manage both the Legal Claim and the Inquiry. The Executive Oversight Group, chaired by the Chief Executive and attended by key Directors, meets fortnightly to ensure effective and swift decision making takes place.

7. LEGAL PROCEEDINGS

7.1 Further to the approval of the Board in January 2019 to raise Court Proceedings against the parties responsible for delivering the QEUH/RHC construction project, NHSGGC engaged MacRoberts LLP to act on its behalf. Court summons were served on the main contractor for the hospital project, Multiplex, and the Health Board's advisors, Currie & Brown UK Limited and Capita Property and Infrastructure Limited.

7.2 Throughout 2020, NHSGGC continued to engage with the appointed legal team within MacRoberts. The process of seeking expert opinion against the 11 Heads of Claim was undertaken which included site visits and preliminary reports from the independent experts to assist on the question of liability.

7.3 In January 2021, the Board considered the position in respect of the claim and the NHS Board approved the instruction of MacRoberts LLP to lodge the action for calling. This was completed on Wednesday 25th January 2021. The case has been remitted to the "Commercial Court" and a hearing on preliminary points was heard on 26th February 2021. The legal debate has been set for June 2021, to be heard by Lady Wolffe.

8. HSE INVESTIGATION

8.1 On 24th December 2019, the Health and Safety Executive (HSE) served on NHSGGC an Improvement Notice in relation to the ventilation system for Ward 4C. Legal advice

was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

8.2 After an initial hearing relating to the Board's appeal against the HSE Improvement Notice, it was agreed that the legal representatives of the HSE and NHSGGC would meet. Due to COVID-19 there was a temporary suspension of activity. An initial hearing was held on 3rd September 2020 with a further preliminary hearing on the 23rd November 2020. The Court has provided a timeline for the appeal to proceed, with a further hearing scheduled for around October 2021.

9. OVERALL SUMMARY

9.1 The many issues described in this paper represent a significant amount of work over the coming months, and indeed years in respect of the Public Inquiry. The resource requirements of the senior leadership team and supporting elements, such as the PMO, have been reviewed and the level of resource to support all areas has been increased. This will be kept under regular review by the Executive team.

Jane Grant
Chief Executive
April 2021

NHSGGC (M) 21/04
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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 29 June 2021 2021 at 9.30 am via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Ms Dorothy McErlean
Cllr Caroline Bamforth	Dr Margaret McGuire
Ms Susan Brimelow OBE	Professor Iain McInnes
Cllr Jim Clocherty	Cllr Sheila Mechan
Mr Alan Cowan	Ms Ketki Miles
Professor Linda de Caestecker	Cllr Iain Nicolson
Ms Jacqueline Forbes	Mr Ian Ritchie
Mrs Jane Grant	Dr Paul Ryan
Cllr Mhairi Hunter	Mr Francis Shennan
Mrs Margaret Kerr	Ms Paula Speirs
Ms Amina Khan	Mrs Audrey Thompson
Mr Allan MacLeod	Mr Charles Vincent
Rev John Matthews OBE	Ms Michelle Wailes
Cllr Jonathan McColl	Mr Mark White

IN ATTENDANCE

Mr Callum Alexander	..	Business Manager
Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Ms Gillian Duncan	..	Secretariat (Minutes)
Mr William Edwards	..	Director of eHealth
Ms Lorna Kelly	..	Interim Director of Primary Care
Ms Christine Laverty	..	Interim Chief Officer, Renfrewshire HSCP
Ms Louise Long	..	Chief Officer, Inverclyde HSCP
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susan Manion	..	Interim Director of GP Out of Hours
Mrs Geraldine Mathew	..	Secretariat Manager
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Julie Murray	..	Chief Officer, East Renfrewshire HSCP
Ms Caroline Sinclair	..	Interim Chief Officer, East Dunbartonshire HSCP
Mr Tom Steele	..	Director of Estates and Facilities
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
46.	**WELCOME AND APOLOGIES**		
	Professor John Brown, Chair, welcomed those present to the June 2021 meeting of the NHS Greater Glasgow and Clyde Board. The meeting combined Members joining via video conferencing and a socially distanced gathering of some members within the Board Room of JB Russell House. Professor Brown reminded Members of the appropriate etiquette during the online discussion and welcomed the members of public who were joining the Board meeting as observers. Member apologies were intimated on behalf of Mr Simon Carr, Ms Anne-Marie Monaghan and Ms Flavia Tudoreanu. Professor Brown extended a very warm welcome to the two new Board Members – Ms Michelle Wailes and Dr Paul Ryan – who had joined the Board on 1 June 2021. Professor Brown also welcomed Ms Christine Laverty who would be replacing Ms Shiona Strachan as interim Chief Officer for Renfrewshire HSCP. Professor Brown thanked Ms Strachan for her much valued contribution to the health and social care system in NHSGGC and, on behalf of the Board, wished her a happy retirement. Professor Brown also advised that this would be Mr Allan MacLeod and Ms Audrey Thompson's last meeting as their terms as Board Members were coming to an end. Professor Brown advised that Dr Lesley Rousselet had taken over from Ms Thompson as Chair of the Area Clinical Forum and had been appointed to the NHS Board from 1 July 2021. Professor Brown also recorded the Board's congratulations to Ms Louise Long, Chief Officer, Inverclyde HSCP, on her appointment as Chief Executive of Inverclyde Council. On behalf of the Board, Professor Brown recorded the Board's congratulations to Mr John Stuart, formerly Chief Nurse North Sector, and Dr Kerri Neylon, Deputy Medical Director for Primary Care, who had been recognised in the Queen's Birthday Honours List. He advised that both Mr Stuart and Dr Neylon had made significant contributions to the success of NHSGGC.		

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	He also recorded the Board's congratulations to Ms Neena Mahal and Mr Tom Herbert who were awarded MBEs. Professor Brown advised that in addition to her work as Chair of NHS Lanarkshire, Ms Mahal had also led work at national level to improve the diversity of the people who sit on the NHS Scotland Boards. Mr Tom Herbert had been actively campaigning for the relocation of some cancer services to Stobhill Hospital and Professor Brown was pleased to see that his commitment had been recognised. Professor Brown also reported that Glasgow Royal Infirmary had been named as Scotland's best hospital as part of a global survey by the US magazine Newsweek. He congratulated everyone involved for this remarkable achievement, including Professor Colin McKay, the Chief of Medicine, Mr John Carson, the Chief Nurse, and Ms Isobel Neil, the Director of the North Sector. Professor Brown advised that Ms Neil had recently retired and recorded his appreciation on behalf of the Board for her contribution to NHSGGC over a long and successful career and wished her a happy retirement. Professor Brown reminded Members that June was Pride month and that while NHSGGC continuously strived for inclusivity and respect for all, he recognised that there were still challenges being faced by LGBTQ+ people, including those who are also from BAME communities, in accessing healthcare and experiencing negative attitudes. Professor Brown stressed the importance of breaking down these barriers and promoting a Health Service that is inclusive for all. He also reminded Members that NHS Scotland had created a new 'Pride Pledge' to promote a message of inclusion, speak up and challenge intolerance. He stressed that it was important that all Board Members joined himself and Mrs Grant in signing the 'Pride Pledge' to show personal and collective support for this important initiative. Professor Brown thanked the Executive Team for providing the papers and Ms Elaine Vanhegan for her work on standardising and improving the presentation of the papers. **NOTED**		
47.	**DECLARATION(S) OF INTEREST(S)**		
	Professor Brown invited Members to declare any interests in any of the items being discussed. Mr Charles Vincent and Mr Francis Shennan both declared an interest in the paper being presented on the Queen Elizabeth		

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	University Hospital and Royal Hospital for Children which did not preclude them from taking part in the discussion. Cllr Jonathan McColl advised that he was now a Councillor member of West Dunbartonshire Integration Joint Board. Professor Brown thanked Cllr McColl and advised that membership of an IJB did not constitute a conflict of interest and would not preclude him from taking part in any discussions. Professor Brown also reminded Members of the requirement to keep their details on the Register of Interest up to date and asked for any changes to be notified to the Secretariat team. **NOTED**		
48.	**MINUTES OF PREVIOUS MEETING**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on 27 February 2021 [Paper No. NHSGGC (M) 21/03]. On the motion of Mr Allan MacLeod, seconded by Ms Audrey Thompson, the minute of the meeting was approved and accepted as an accurate record. **APPROVED**		
49.	**MATTERS ARISING**		
	The Board considered the Rolling Action List of the NHSGGC Board [Paper No. 21/26]. Professor Brown asked the Board if they had any matters arising that they wished to raise. No matters were raised and Members agreed to the closure of the 8 actions noted on the Rolling Action List. **APPROVED**		
50.	**CHAIR'S REPORT**		
	Professor Brown reported that he had attended and contributed to a wide range of meetings since the April Board meeting. These included the Acute Services Committee, Clinical and Care Governance Committee, Finance, Planning and Performance Committee and the Audit and Risk Committee.		

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	Professor Brown had met with the Standing Committee Chairs on 22 June 2021. He had also had a number of conversations with individual Board Members as part of the process to confirm roles and responsibilities for the rest of this year. Details of the outcomes of those discussions had been included as an appendix to the paper on Active Governance that would be discussed later in the agenda. Professor Brown had met with the West of Scotland Chairs Group and the NHS Scotland Board Chairs Group. A wide range of issues that affected all Boards in Scotland was discussed, however, these were still predominately about the NHS Scotland response to the COVID-19 pandemic. Professor Brown had also attended the NHS Scotland Board Chairs first meeting with the new Cabinet Secretary for Health and Social Care, Mr Humza Yousaf MSP, and his team. .Ms Maree Todd MSP, the Minister for Public Health, Women's Health and Sport, and Mr Kevin Stewart MSP, Minister for Mental Wellbeing and Social Care. The Cabinet Secretary had also invited Ms Angela Constance MSP, Minister for Drugs Policy, to attend this session and she had spoken to the Board Chairs about her latest thinking on tackling the drugs problem in Scotland. Professor Brown reported that the Cabinet Secretary had described his priorities as steering the NHS out of the COVID-19 pandemic while being realistic about recovery and renewal, and taking care of the workforce. He advised that all of these ambitions were reflected in the NHSGGC Remobilisation Plan that would be discussed later in the agenda. Professor Brown had also attended a new group that had been set up by the NHS Scotland Board Chairs to consider how efforts to improve population health and reduce health inequalities could be supported. He advised that Mr John Matthews was leading on this for the Board and had been invited to join this group. Mr Ian Ritchie had also been invited to contribute given his lead responsibility for mental health issues at Board level. Professor Brown advised that the Board would be updated on how this progressed through the Public Health Committee. Professor Brown had also chaired the Glasgow Centre for Population Health Board Meeting. He also continued to work with colleagues on the NHS Scotland Corporate Governance Steering Group to further develop the NHS Scotland approach to Active Governance.		

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	Professor Brown continued to chair the NHS Scotland Global Citizenship Advisory Board and as part of this work had been discussing the possibility of launching a new charity to support this important work with a small group of experts in this field. Professor Brown advised that he and the Chief Executive had reinstated their regular meetings with MSPs and MPs now that the Scottish Parliament elections had taken place. He reported that the first two meetings had gone well and the main topic of discussion had been the NHSGGC response to the COVID-19 pandemic. Professor Brown and Mrs Grant had visited the new Greenock Health Centre and had been very impressed by the new building and the services it provide to the local population. Professor Brown and Mrs Grant had also accompanied the Cabinet Secretary on a visit to Glasgow Royal Infirmary to see the new Da Vinci robot that would help to improve surgical outcomes and reduce waiting times for patients. Professor Brown had also been invited to present the Quality Improvement Awards to teams from the Acute Division's South Sector which had included the Dame Denise Coia Award for Quality Improvement in Patient Care. Professor Brown and Mrs Grant had met with Lord Brodie and David Shepard QC when the Public Inquiry Team visited the QEUH Campus on 23 June 2021. Professor Brown reported that the visit had gone well and Lord Brodie had been complimentary about the reception he had received and the people that he had met while touring the hospitals. Finally, Professor Brown advised that he had continued to work with Professor Michael Deighan and the participants in the Royal College of Physicians of Edinburgh (RCPE) Governance Fellowship. The third development session with the NHSGGC participants had taken place on 24 June 2021 and Professor Brown was pleased to report that the programme was going well and the improvement projects that had been referred to in the Active Governance paper discussed at the April Board were beginning to take shape. **NOTED**		
51.	**CHIEF EXECUTIVE'S REPORT**		
	Mrs Grant reported that she continued to be involved in a significant number of discussions, both locally and nationally,		

			ACTION BY
	around the COVID-19 pandemic, particularly focusing on the balance between remobilisation and ensuring the NHS in Scotland was prepared for the potential of a third wave. Mrs Grant reported that the first meeting of the Advice, Assurance and Review (AARG) Group which had been set up by the Scottish Government to replace the Oversight Board Structure had taken place on 7 June 2021 chaired by Professor Amanda Croft, Chief Nurse, Scottish Government. Mrs Grant advised that she had also had a number of interactions with the new Ministers. This had also included a meeting with Ms Maree Todd MSP who had outlined her view on the next steps for the Best Start programme for neonatal and maternity care. Mrs Grant had also attended a joint NHS Board and Local Authority Chief Executives meeting. She reported that this had been a productive meeting and they had discussed innovation over the last year and how this could be continued and expanded on while ensuring a focus on reducing inequalities. As reported by the Professor Brown, Mrs Grant was pleased to report that Ms Christine Laverty had been appointed as the Interim Chief Officer of Renfrewshire HSCP. She advised that a new senior member in the Corporate Services team and a new Acute Director had been appointed as well as a Director of Access. Mrs Grant was pleased to report that notification had been received that the Board had been de-escalated from Level 4 to Level 2 on the NHS Scotland Performance Management Framework for performance issues which was a significant achievement, particularly given the COVID-19 pandemic. Mrs Grant advised that NHSGGC remained at Level 4 in terms of infection control. Professor Brown thanked Mrs Grant for the update and welcomed the de-escalation which reflected the hard work and commitment of Mrs Grant and the rest of the team. **NOTED**		
52.	**PATIENT STORY**		
	Dr Margaret McGuire, Nurse Director, presented the patient story which was particularly relevant as it followed the COVID-		

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	19 vaccination journey of a young person with learning disabilities and complex health needs. Dr McGuire said that this story reflected how the special arrangements and extra support that had been made possible by liaison between staff and services had ensured this had been a positive experience for the young person and his family. Professor Brown thanked Dr McGuire for the presentation and said this had been a great opportunity for NHSGGC to act as a learning organisation and was an excellent example of patient centred care. Professor Brown advised that the patient story for a future Board Meeting would reflect the discussions that had taken place previously about the NHSGGC response to equalities and human rights and the importance of hearing about the experiences of other communities, such as LGBTQ+ and BAME. **NOTED**		Dr McGuire
53.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update [Paper No. 21/27] presented by Mrs Jane Grant, Chief Executive. As noted during the Chief Executive update, Mrs Grant advised that the first meeting of the AARG had taken place on 7 June 2021. Mrs Grant advised that this first meeting had been positive and the Action Plans relating to the QEUH and RHC had been well received as had the progress that had been made to date. She advised that around a third of the recommendations had been completed and the remainder were in progress. A full briefing on the recommendations and actions had been provided to the Finance, Planning and Performance Committee at its meeting on 15 June 2021. Mrs Grant advised that the Terms of Reference for the AARG had been approved and further meetings were being arranged for August and September 2021. Mrs Grant reassured the Board that collaborative work with the Scottish Government also continued outwith the AARG meeting.		

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	In terms of the Public Inquiry, Mrs Grant advised that Lord Brodie had has team had visited the QEUH and RHC on 23 June 2021. Mrs Grant advised that the first substantive hearings would commence in September 2021 and would focus on understanding the experiences of affected patients and their families. Work was also ongoing to respond to the information request received in February 2021. Mrs Grant advised that the completion date for Ward 2A/2B at the RHC had still to be confirmed but this was expected to be the end of August and thereafter a date for the wards reopening would be agreed. Mrs Grant advised that feedback on the legal claim was expected in early July. Mrs Grant also advised that the dialogue on the HSE Improvement Notice was ongoing. Mrs Grant reported to the Board that there was an emerging issue in relation to internal wall panels at the QEUH and Mr Tom Steele, Director of Estates and Facilities, was invited to provide further detail on this. Mr Steele reported that work had been ongoing with Multiplex over the last few months regarding internal wall panels and it had been decided that the best remedial option was to remove these. Mr Steele advised that as well as going through due diligence with building standards there had been close contact with the fire and rescue service who had confirmed they were satisfied with the measures undertaken so far and the remedial proposals. Mr Steele advised that there was a considerable cost associated with this but at the moment it was expected this would be met by Multiplex. In response to a question about the legal claim for the cold water system, Mr Steele clarified that this was a separate claim that had been formally lodged in court but would be heard at same time at the end of July. Professor Brown thanked Mr Steele for the update and confirmed that the recent Finance, Planning and Performance Committee had received a detailed update on these issues. In response to a query about Ward 2A/2B, Mr Steele confirmed that there would be a significant amount of post-handover work undertaken before the wards would re-open, including independent tests and validation. Dr McGuire said that it was appreciated that there would be considerable anxiety and sensitivity around the reopening and she		

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	confirmed that there would be communication with patients, families and staff to provide reassurance in advance of the wards opening. Mr Steele confirmed that the ongoing programme of remedial work at the QEUH and RHC was already underway and NHSGGC was currently looking to appoint a long-term construction partner. He reassured the Board that there was no impediment to starting the process and the remedial work was not dependent on the outcome of the legal activity. The Board were content to note the update. **NOTED**		
54.	**COVID–19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 21/28] presented by Professor Linda de Caestecker, Director of Public Health. Professor de Caestecker provided an overview of the current position in respect of the NHSGGC response to the COVID-19 pandemic. She reported that the number of cases had been increasing since the start of May and that all Local Authorities in NHSGGC were over 300 cases per 100,000 currently with the highest number of recent cases being seen in the 18-24 age group. Professor de Caestecker advised that the effect on the workforce had increased which was mainly due to staff having to self-isolate. There had also been an increase in the number of hospital admissions but this was not to the same level as had been seen previously. There were currently no significant concerns in relation to Care Homes. Professor de Caestecker advised that the rising number of cases had led to a corresponding increase in the demand on the test and protect service. New contact tracing staff were being recruited and some contact tracing processes had been changed in line with national processes. Professor de Caestecker advised that the vaccination programme was continuing at pace and NHSGGC was on track to complete all first doses in July and second doses by the middle of September. Professor de Caestecker was asked about the two different definitions used to measure the number of COVID-19 cases in		

			ACTION BY
	hospital and whether the reporting of the <28 day definition could cause complacency among the population as this was a much smaller number. Professor de Caestecker explained that the <28 day definition was more important in terms of epidemiology and testing which is why it was widely used to report the number of cases. She also reported that patients were less unwell and in hospital for less time than had been seen previously. It was noted that the higher figure included the whole NHSGGC area and not just Acute beds. The Board was advised that Professor Iain McInnes had been the Chief Investigating Officer for the UK on the OCTAVE trial which was looking at the impact of the COVID-19 vaccination on vulnerable groups and the results of that study would begin to be reported within the next few weeks. Professor de Caestecker was asked about booster vaccinations. She advised that confirmation and guidance was awaited from the JCVI but planning for the flu vaccination programme and COVID-19 boosters was underway on the assumption that there would be similar priority groups as before. In response to a query about long-COVID, Professor de Caestecker advised that work was underway both nationally and locally on long-COVID and how this would be best assessed and managed. She advised that she would provide a further update on this in August. Professor de Caestecker was asked if there were issues with delays in the reporting of COVID-19 test results and whether this posed any risk to NHSGGC. She provided reassurance that any backlog in reporting had related to dataflow and not the analysis of tests and that NHSGGC was not only reliant on one laboratory. Professor de Caestecker responded to a query about capacity after the Hydro closed as a vaccination centre in mid-July. She advised that additional capacity would be put into community clinics and opening times and space could be expanded as required. In response to a query about the change from 12 weeks to 8 weeks for second vaccinations, Professor de Caestecker advised that there had been a recent issue when the national system had sent out appointment letters early in error but that had been resolved quickly. She confirmed that appointments could be changed via the online portal. In response to a query about self-isolation, Professor de Caestecker said that the guidelines on this were being		Prof de Caestecker

			ACTION BY
	followed but discussions were taking place nationally on whether this would continue or if this would move to daily testing. Mr Jonathan Best, Chief Operating Officer, said that while there had been a slight increase in the number of staff who were self-isolating this had not had an impact on services and he provided assurance that staffing was closely monitored every day. The Board were content to note the COVID-19 update **NOTED**		
55.	**NHSGGC PERFORMANCE UPDATE**		
	The Board considered the paper 'NHSGGC Performance Update' [Paper No. 21/29] presented by Mr Mark White, Director of Finance. Mr White advised that the report outlined the performance against the Key Performance Indicators (KPIs) outlined in the Remobilisation Plan 3 between 1 April 2021 to 31 May 2021. Mr White advised that the suite of measures had been split into actual targets and key metrics He reported that in terms of performance against the KPIs, there were 7 green, 3 red and one not applicable. He assured the Board that the Finance, Planning and Performance Committee had gone through the KPIs in detail at its recent meeting. Professor Brown thanked Mr White for the update and said that to have achieved seven green out of eleven performance measures in the current situation was a significant achievement and he commended everyone involved. In response to a query about Delayed Discharges and Adults with Incapacity (AWI) numbers, Dr McGuire said that although the court processes had recommenced, this was still a slow process and there were also a number of other factors that also impacted on Delayed Discharges. She advised that work with HSCPs and others on reducing Delayed Discharges was continuing with important work planned over the next few months. There was a question on whether the number of A&E and attendances and emergency admissions were linked to pressure in other parts of the system. Mr Best advised that the A&E attendances were from a variety of sources. With regards to emergency admission, Mr Best said that there		

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	would always be a percentage of patients admitted after presenting at Emergency Departments (EDs) and as the EDs were returning to pre-COVID levels of attendance the number of admissions had increased. Ms Susanne Millar, Chief Officer Glasgow City HSCP, was invited to respond to concerns about waiting times for CAMHS and Psychological Therapies. Ms Millar said she shared the Board's concerns at the current performance and advised that there had been an increase in the number referrals and a higher acuity of patients. She provided assurance that work was ongoing to reduce waiting times while ensuring patients on the list were supported and offered quick access to urgent care if their condition changed. The Board noted that there had been significant improvement in GP Out of Hours (OOH) activity and considerable work had been undertaken to stabilise the workforce and increase the cohort of GPs in the service. Professor Brown asked for the Board's appreciation for this to be passed on to the GP OOH service. Dr McGuire was asked to respond to a query about staff turnover in mental health services. In terms of nursing, she advised that the demographics demonstrated a high proportion of nurses in the 50 plus age range, many of whom were likely to retire in the near future. She advised that work was underway to encourage these staff to remain in the service or return to work on a part time basis. She also advised that some of the high turnover had been as a result of staff development, enabling nurses to move to specialist and promoted posts. As well as recruitment of newly qualified nurses work was underway on retention and recruitment to ensure that vacancies could be filled in a timely manner Ms Millar also provided reassurance that the Mental Health Programme Board had a workforce workstream which looked at these issues. The recruitment of Consultant staff was also a national issue. Mrs MacPherson agreed and advised that there had been some success in recent recruitment campaigns and work was underway with Chief Officers and Human Resources colleagues in HSCPs looking at career pathways and creating opportunities while retaining staff. In response to a query about support in the community for mental health, Professor Brown suggested that it was important to look at the role of local groups in supporting mental health and NHS Boards across Scotland were looking		

			ACTION BY
	at new ways of working with partners in the third sector as they came out of the COVID-19 pandemic. In response to a query about the average length of stay for emergency admissions compared to the target, Mr Best advised that this had not been a typical 18 months in terms of the type and acuity of patients admitted to hospital, but this as was now returning to pre-COVID levels the average length of stay had been reducing. Mrs Grant agreed and said that this might be fluid for the next few months depending on the impact of COVID-19 and the target could be revisited for the next Remobilisation Plan. **NOTED**		
56.	**THE HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Report' [Paper No. 21/30 presented by Professor Angela Wallace, Executive Director of Infection Prevention and Control. Professor Wallace provided an overview of the key elements of the report. She advised that the format of the Board report had changed and this was now a summary report and the full Healthcare Associated Infection Reporting Template (HAIRT) that was submitted to the Scottish Government had been considered in detail at the Clinical and Care Governance Committee at its meeting on 8 June 2021. Professor Wallace advised that this was a positive and stable report in relation to Infection Control during March and April 2021. She advised that NHSGGC's performance against the key infection control AOP targets remained within accepted ranges. Professor Wallace advised that there was significant progress on the Infection Control whole system Improvement Network and that staff had responded well to the challenges of improving the system across NHSGGC. This work is designed to further improve performance against the Infection Control standards. She added that the dedicated actions in the QEUH and RHC Action Plans relating to Infection Control were all on track. She highlighted that two areas, ie, the IMT process review and the infection control processes benchmarking work were also		

			ACTION BY
	on track and more information on this would be provided in the August update. Professor Brown thanked Professor Wallace for the update. He welcomed the positive report and assurance that the current system was recording infection rates within acceptable levels and he was keen that the public were aware that hospitals across NHSGGC were safe. In response to a query about why NHSGGC was still at Level 4 on the performance escalation framework given the positive reports, Professor Wallace said that she continued to provide information and evidence of the positive work that was ongoing in NHSGGC and was working closely with the Scottish Government to ensure that this information was shared as part of the Scottish Governments Assurance Advice and Review group (AARG) aspects was balanced and impactful. The Board were content to note the Healthcare Associated Infection Report. Professor Brown thanked Professor Wallace for her insight and her assurance that the progress made would be reported back to the AARG, who in turn would consider the Board's position in relation to the NHS Scotland Performance Management Framework. **NOTED**		
57.	**NHSGGC FINANCE UPDATE**		
	The Board considered the paper 'NHSGGC Finance Update' [Paper No. 21/31] presented by Mr Mark White, Director of Finance. This paper provided the Board with the month 12 financial position and Mr White said that the key message was that NHSGGC had achieved its three financial targets, ending the year with a small revenue surplus of £0.5 million. However, this financial balance had been underpinned by the additional funding received for COVID-19. This would now be subject to the external audit process and was therefore subject to change. Mr White advised that there had, however, been an increase in the underlying recurring deficit and reducing this would be a key priority for this financial year.		

			ACTION BY
	In response to a query about the Financial Improvement Programme (FIP) given the continued uncertainty around COVID-19, Mr White agreed that this would be challenging but advised that the FIP Performance Management Board had been established and the Executive Directors were looking at ways to make efficiency savings. In response to a query around prescribing budgets, Dr Jennifer Armstrong, Medical Director, advised that there were pharmacists in primary care teams providing advice to patients and GPs as it was incumbent on all NHS Boards to ensure best value for money. She advised that considerable savings were made each year by prescribing generic drugs and this was routine for all NHS Boards. In response to a query about the difficulties in engaging staff in discussions around financial savings in the current climate, Mrs Grant agreed that staff have worked extremely hard over the last 18 months and it would be difficult to focus on financial savings. However, she stressed that this work was important and engagement with clinical teams would be key to building on the collaborative work that had been undertaken over the last 18 months. Professor Brown thanked Mr White for the update and the Board was content to note: - the revenue position at Month 12, the projection to the year-end and the initial financial settlement position. - the capital position at Month 12. - the initial outlook into 2021/22. **NOTED**		
58.	**REMOBILISATION PLAN (RMP3)**		
	The Board considered the paper 'Remobilisation Plan (RMP3)" [Paper No. 21/32] presented by Dr Jennifer Armstrong, Medical Director. Dr Armstrong also provided a presentation to the Board describing the key commitments and priorities in the RMP3. She said that the RMP3 aimed to set out a realistic way forward in dealing with the COVID-19 and remobilisation while not losing sight of the longer-term aims of Moving Forward Together (MFT). Professor Brown thanked Dr Armstrong and said the RMP3 was an impressive piece of work. He said the key message		

			ACTION BY
	was that remobilisation had started and would be ongoing for some time, innovation and best practices had been identified and none of this would be possible without the support of the staff. In response to a query around social prescribing and the concern about over-prescribing in mental health, Dr Armstrong said there had been discussions at the Area Clinical Forum on ensuring people were signposted to where they can get help and providing reassurance that anxiety concerning the pandemic was normal in some instances and may require signposting to support services to help people cope. Ms Millar agreed and said that there was a significant piece of work being led by the HSCPs to maximise independence and support people earlier in their mental health journey. She also advised that the Mental Health Strategy had clear objectives about mental health support in primary care and working with people in their local community In response to a query regarding the recording of ethnicity by services, Mr William Edwards, Director of eHealth, advised that the Scottish Government had written to NHS Boards asking that this was recorded as part of a national dataset, however, he provided assurance that the right to refuse to disclose this information was paramount. There was a query about how long it would take to recover and whether MFT would be refined as new ways of working post COVID-19 were identified. Dr Armstrong said COVID-19 continued to have an impact on capacity planning and service delivery across the UK and recovery would take time. She advised that MFT had been looked at as part of this process. Dr Armstrong said that the RMP3 was a complex piece of planning that set out the key priorities for COVID-19 and remobilisation over the next year. Work was also underway to look at what changes that had been made over the last 18 months should be retained and built on and in addition to surveying clinicians, patients had been asked their views on changes in services such as GPOOH and this had elicited a positive response. Professor Brown said the recovery and reform approach outlined in the paper gave the Board assurance and patient and staff engagement was key to taking this forward. He noted that operational capacity plans were being developed to support RMP3 and he said that the new MFT Advisory Group would be considering how COVID-19 impacted on the MFT.		

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	Ms Dorothy McErlean, Employee Director, said that it was important that staff were involved in the changes and listened to, while taking cognisance of what they've been through over the past 18 months. Professor Brown agreed and said that it would be important to be assured of partnership working in developing and delivering the detail of the plan. There was also discussion around equality and ensuring this would be integrated within the Strategic Plans. Mrs MacPherson said that there was an active workforce group and staff network. Professor Brown said the LGBTQ+ survey was a good starting point to build on. He said it was important to see staff as service users as well as staff members. In response to a query about ensuring integration across the system and the importance of patients and staff being aware of services available, Ms Sandra Bustillo, Director of Communications and Public Engagement, advised that there were regular meetings with the Local Authority and HSCP Communications Teams and that they used each other's networks for messaging across the system. This would augment the promotion of services and ensure cross-system understanding of what is available. In response to concerns about whether the shift to digital platforms had meant barriers for some people in terms of Public Involvement and Public Engagement, Ms Bustillo advised that the Communications and Engagement Team was working to ensure a blend of online, in person and telephone contact while physical engagement was restricted. Within some service elements there was also dialogue with clinical teams and patients about changes to service. Professor Brown thanked Dr Armstrong and everyone involved in pulling together this comprehensive plan. The Board was content to approve the RMP3. **APPROVED**		
59.	**IMPLEMENTING THE ACTIVE GOVERNANCE APPROACH**		
	The Board considered the paper 'Implementing the Active Governance Approach" [Paper No. 21/33] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration.		

			ACTION BY
	Ms Vanhegan advised that this paper provided an update on Phase 1 of the approach being taken to implement active governance in NHSGGC. She confirmed that all Phase 1 actions had been delivered and good progress continued to be made across all other phases of the Active Governance programme. In response to a query about the role of the Board Champions, Professor Brown clarified that these were not operational roles and the key responsibilities were set out in the paper. He confirmed that it had been agreed that there were currently two Diversity Champions, one focused on BAME and one focused on Disability. He stressed that diversity was everyone's responsibility and all Board Members had a role in ensuring that was understood and embedded across NHSGGC. In response to a query around the organisation's capacity and capability in terms of risk management, Mr White said that in addition to the expert input from Azets, it was important to remember that there was also an internal risk resource. Further discussion on risk would take place at the development session on 27 July 2021. The Board were assured as to the position with the Active Governance programme and would receive an update on Phase 2 at the meeting on 17 August 2021. The allocation of Board Members to Standing Committees and IJBs as set out in Appendix B was approved subject to the following amendments: - Mr Alan Cowan was now Chair of Inverclyde IJB. - Ms Margaret Kerr would become Chair of the Audit and risk Committee and join the Finance, Planning and Performance committee when Mr Allan MacLeod demitted from his role at the end of July. The Board noted the Annual Cycle of Business set out in Appendix C of the paper. The Board approved the Terms of Reference for the Standing Committee Chairs network and the Integration Joint Boards Leads Network set out in Appendices D and E. The Board noted that Ms Jennifer Haynes had taken on the role of Board Secretary and the key aspects of that role were set out in Appendix F of the paper. **APPROVED**		Ms Vanhegan Ms Vanhegan

			ACTION BY
60.	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**Finance, Planning and Performance Committee**		
	The Board were content to note the Chairs Report of the Finance, Planning and Performance Committee held on 15 June 2021 [Paper No. 21/34]. **NOTED**		
b)	**Audit and Risk Committee**		
	The Board were content to note the Chairs Report of the Audit and Risk Committee held on 22 June 2021 [Paper No. 21/35]. **NOTED**		
c)	**Clinical and Care Governance Committee**		
	The Board were content to note the Chairs Report of the Clinical and Care Governance Committee held on 8 June 2021 [Paper No. 21/36]. **NOTED**		
d)	**Staff Governance Committee**		
	i) Minute of the meeting held on 15 April 2021 The Board were content to note the minute of the Staff Governance Committee held on 15 April 2021 [SGC(M) 21/02]. **NOTED**		
	ii) Chair's report of the meeting held on 11 May 2021 The Board were content to note the Chair's Report of the Staff Governance Committee held on 11 April 2021 [Paper No. 21/37]. **NOTED**		
e)	**Area Clinical Forum**		
	i) Minute of the meeting held on 8 April 2021		

			ACTION BY
	The Board were content to note the minute of the Area Clinical Forum held on 8 April 2021 [ACF(M)21/02]. **NOTED**		
	ii) Chair's report of the meeting held on 10 June 2021 The Board were content to note the Chair's report of the Area Clinical Forum held on 10 June 2021 [Paper No. 21/38]. **NOTED**		
61.	**ANY OTHER BUSINESS**		
	Professor Brown closed the business of the meeting and asked the Board to record and reflect on losing two key Board Members, Mr Allan MacLeod and Ms Audrey Thompson. Professor Brown advised that Ms Thomson had joined the Board in July 2017 and had made a significant impact on the work of the Area Clinical Forum and was an active and valued contributor to the Acute Services Committee and the Clinical and Care Governance Committee, as well as a great success in her day job. Professor Brown advised that Mr Allan MacLeod had joined the Board in 2015 and had brought with him a wealth of experience of problem solving as well as an inclusive and collaborative style to supporting the Board and its Committees. He was grateful for MacLeod's perspective and advice from his background as a Finance Director On behalf of the Board, Professor Brown thanked Ms Thomson and Mr MacLeod for their hard work and support and wished them well for the future. Professor Brown advised that an extra Board meeting was being arranged for September to approve the Annual Accounts and formal notification of this would be sent shortly. There were no other items of business raised. Professor Brown closed the meeting by thanking the Board Members for a comprehensive discussion. He also offered his thanks to the Executive Team for producing the suite of Board papers and for all the support they provided to the Board.		Ms Vanhegan

			ACTION BY
62.	**DATE AND TIME OF NEXT SCHEDULED MEETING**		
	Tuesday 17 August 2021 at 9:30 am via MS Teams		

NHS GGC COVER PAPER

NHS Greater Glasgow and Clyde	**Paper No. 21/27**
Meeting:	**NHS Board**
Meeting Date:	**29 June 2021**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Chief Executive**
Report Author:	**Head of Corporate Governance**

1. Purpose

The purpose of the attached paper is to:

- Update the Board on the positon in respect of a range of issues regarding the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC).

2. Executive Summary

The paper can be summarised as follows:
The paper describes

- The establishment of the Action and Assurance Group (AARG) replacing the previous Oversight Board and chaired by Prof Amanda Croft, Chief Nurse.
- The progress with the Public Inquiry and future hearings.
- The current position of the Legal Claim.
- Wards 2A/B refurbishment.
- The HSE Appeal position.

3. Recommendations

There are no formal recommendations within the paper**.**

4. Response Required

This paper is presented for assurance.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- **Better Health** **Positive**
- **Better Care** **Positive**
- **Better Value** **Neutral**
- **Better Workplace** **Positive**
- **Equality & Diversity** **Neutral**
- **Environment** **Neutral**

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity: The issues described within the paper are subject to wide engagement across the organisation with each aspect led by a Corporate Director.

7. Governance Route

This paper has been previously considered by the following groups as part of its development: The issues described have been considered by the Executive Oversight Group, chaired by the Chief Executive on a fortnightly basis, onwards to the Corporate Management Team monthly and the Finance Planning and Performance Committee on 15th June.

8. Date Prepared & Issued

Prepared 21 June 2021 and circulated 25 June 2021

NHS GGC COVER PAPER

NHS Greater Glasgow and Clyde	**Paper No. 21/27**
Meeting:	**NHS Board**
Meeting Date:	**29 June 2021**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Chief Executive**
Report Author:	**Head of Corporate Governance**

1. Introduction

This paper is presented to the Board to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided to the committee for the purposes of information and assurance.

2. Background

Board members will be familiar with the issues in respect of the QEUH and the RHC subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of Legal action against Multiplex, Currie and Brown and Capita, the Scottish Hospitals Public Inquiry, the position in respect of 2A/B and the ongoing HSE Appeal. This paper provides an update.

3. Assessment

3.1. Oversight Board

3.1.1 The Board received an update at the April meeting in respect of the Oversight Board Report and the Case Note Review Report, both published on 22nd March 2021. It was highlighted that a comprehensive action plan to address all the recommendations, including those of the Independent Review led by Drs Montgomery and Fraser, had been put in place to address the issues described. A specific delivery group (Gold Command), chaired by the Chief Executive, has been established to provide updates to the Corporate Management Team and, in turn, to

the appropriate governance committee of the NHS Board to ensure focused work is undertaken on all of the recommendations. The Finance Planning and Performance Committee (FP&P) will oversee delivery of the overall plan. A presentation detailing action to date was presented to the Committee.

3.1.2 The Scottish Government has established the Advice Assurance and Review Group (AARG) which replaces the Oversight Board structure. The first meeting took place on the 7th June, chaired by the Chief Nurse, Professor Amanda Croft, who was supported by a number of Scottish Government colleagues. NHS GGC representation included Jane Grant, Chief Executive and corporate colleagues responsible for the delivery of the recommendations across the reports. The Terms of Reference were approved with a further meeting being scheduled. Overall, the AARG were content with the plans and indicated that they considered excellent progress had been made at this stage.

3.2. Public Inquiry

3.2.1 The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. On 19th January 2021 Lord Brodie announced timescales for 2021 and on the 1st February 2021 issued core participants with formal evidence requests.

3.2.2 Lord Brodie and some of the Inquiry Team visited the QEUH and RHC on Wednesday 23rd June, the purpose of which was to orientate themselves with the site and some of the services provided. Lord Brodie met with the Chairman and Chief Executive at the end of the visit where the supportive and proactive approach that GGC is taking to the Public Inquiry was emphasised.

3.2.3 The first formal hearing of the Inquiry took take place on Tuesday 22nd June 2021. This was a procedural hearing and can be viewed on the Public Inquiry You tube channel https://www.youtube.com/channel/UCSZ-PcFxijaBCjvTIPZlEHQ. The first substantive hearings of the Inquiry will commence on Monday 20th September 2021 and will last for five weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those called upon to give evidence in person at the initial hearings.

3.2.4 It is likely that the next set of hearings will be scheduled for late 2021 /early 2022, with a procedural hearing ahead of that time. Further details of what will be covered and the programme for the hearings will be published in due course, however it has been indicated that the initial focus will be on the inquiry into the Royal Hospital for Children and Young People in Edinburgh.

3.2.5 Significant activity is underway to respond to the first information request received on 1st February around the 3 priority areas noted below;

- A/ Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care.
- B/ Governance and Project Management.
- C/ Effects of the issues identified on patients and their families.

3.2.5 A number of meetings have been held with the dedicated team from the Central Legal Office and Inquiry Team Solicitors with documents now being transferred as requested in a coordinated manner. This is likely to continue for a number of months.

3.2.6 The Programme Management Office (PMO) resources have been increased with a single Project Team being created to manage both the Legal Claim and the Inquiry in light of the significant cross over in terms of issues, management and information. The Executive Oversight Group, chaired by the Chief Executive and attended by key Directors, meets fortnightly to ensure effective and swift decision making takes place.

3.3 *Legal Claim*

3.3.1 The legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd. and Capita Property and Infrastructure Ltd. was lodged on 22 January 2020. Action was lodged with the Court for calling on Monday 25th January 2021. The case has been remitted to the "Commercial Court". Hearings on preliminary points were heard on 26th February and 20th May 2021.

3.3.2 Prior to lodging the action in January 2021, MacRoberts LLP provided NHS GGC with legal advice notes on the prospects of success in relation to each of the claims in the Court Action. The legal advice notes incorporated preliminary expert reports by independent technical experts and indicated that there were grounds to continue to pursue across all heads of claim. There is regular exchange of information, review and decisions required to meet the defined timescale to prepare for the legal debate.

3.3.3 To date the Board has required to expend resources as a result of reactive maintenance and repairs and some specific rectification or risk mitigation works. Full rectification of the technical issues is complex, requiring careful planning, phasing and diligent qualitative review of proposals. Counsel opinion is being sought on the prospects of success in relation to each of the claims in the Court Action with feedback is expected in early July.

3.4 *Ward 2A/2B*

The engineering systems re-fit and refurbishment of wards 2A and 2B is nearing completion and it is anticipated that it will be handed over to NHS GGC by September, although this date should be considered indicative at this stage. Thereafter, specialist independent commissioning and validation will take place prior to clinical commissioning and service commencement. At present the project team are finalising the arrangements with Ward staff and a firm date will be set in the forthcoming weeks. A wider communications note will be issued to patients, families and staff as well as other key stakeholders to ensure that the handover and transition happens seamlessly.

3.5 *HSE*

3.4.1 On 24th December 2019, the Health and Safety Executive (HSE) served on NHSGGC an Improvement Notice in relation to the ventilation system for Ward 4C.

Legal advice was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

3.4.2 After an initial hearing relating to the Board's appeal against the HSE Improvement Notice, it was agreed that the legal representatives of the HSE and NHSGGC would meet. Due to COVID-19 there was a temporary suspension of activity. An initial hearing was held on 3rd September 2020 with a further preliminary hearing on the 23rd November 2020. The Court has provided a timeline for the appeal to proceed, with a further hearing scheduled for around October 2021. Dialogue continues with the CLO and respective Counsels.

4. Conclusion

Significant activity continues across all the strands of work related to the QEUH which is likely to increase even further in the coming months. The resource requirements of the senior leadership team and supporting elements, such as the PMO, remain under constant review. The senior team are clear of the priority that is required to ensure we respond effectively to the many requirements.

5. Recommendations

There are no specific recommendations.

6. Implementation

The Board will be regularly updated on the position regarding the implementation of recommendations from the respective reports.

7. Evaluation

Not applicable at this stage.

8. Appendices

There are no appendices to this paper.

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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 17 August 2021 at 9.30 am via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Ms Ketki Miles
Cllr Caroline Bamforth	Ms Dorothy McErlean
Ms Susan Brimelow OBE	Ms Anne-Marie Monaghan
Mr Simon Carr	Cllr Iain Nicolson
Cllr Jim Clocherty	Mr Ian Ritchie
Mr Alan Cowan	Dr Lesley Rousselet
Professor Linda de Caestecker	Dr Paul Ryan
Mrs Jane Grant	Mr Francis Shennan
Cllr Mhairi Hunter	Ms Paula Speirs
Mrs Margaret Kerr	Ms Rona Sweeney
Ms Amina Khan	Ms Flavia Tudoreanu
Rev John Matthews OBE	Mr Charles Vincent
Dr Margaret McGuire	Ms Michelle Wailes
Cllr Sheila Mechan	Mr Mark White

IN ATTENDANCE

Mr Callum Alexander	..	Business Manager
Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Ms Gillian Duncan	..	Secretariat
Dr Emila Crighton	..	Deputy Director of Public Health
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Ms Lorna Kelly	..	Interim Director of Primary Care
Ms Louise Long	..	Chief Officer, Inverclyde HSCP
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susan Manion	..	Interim Director of GP Out of Hours
Mrs Geraldine Mathew	..	Secretariat Manager (Minutes)
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Mr Iain Paterson	..	Corporate Services Manager
Ms Caroline Sinclair	..	Interim Chief Officer, East Dunbartonshire HSCP
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
63.	**WELCOME AND APOLOGIES**		
	Professor John Brown, Chair, welcomed those present to the August 2021 meeting of the NHS Greater Glasgow and Clyde Board. The meeting combined members joining via video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were reminded to observe appropriate etiquette, and presenters were asked to provide short presentations to highlight key points. Professor Brown extended a warm welcome to the new Board member, Dr Lesley Rousselet. Dr Rousselet has been appointed as the new Chair of the Area Clinical Forum and has been appointed to the NHSGGC Board as a stakeholder member. Professor Brown welcomed members of the public who had joined the Board meeting as observers. Board member apologies were intimated on behalf of Ms Jacqueline Forbes, Cllr Jonathan McColl, and Professor Iain McInnes. Officer apologies were intimated on behalf of Mr Tom Steele, Ms Julie Murray, and Mr William Edwards. Professor Brown provided a brief overview of the items to be considered at today's meeting. He noted that there were three late papers, those being:- • Item 10 – Paper 21/42 – NHSGGC Integrated Performance Report • Item 11 – Paper 21/43 – NHSGGC Revenue and Capital Report • Item 16bi – Paper 21/50 – Chairs Report of the Finance, Planning and Performance Committee meeting of 10th August 2021 Professor Brown asked Board members to confirm if they had any objections to accepting the late papers for consideration at today's meeting. Members were content to accept the late papers for consideration. **NOTED**		

			ACTION BY
64.	**DECLARATIONS OF INTEREST**		
	Professor Brown invited members to declare any interests in any of the items being discussed. A declaration of interest was made by Ms Paula Speirs, in respect of her post as Director of Strategy, Planning and Performance, NHS24. The Board were content to note the declaration. **NOTED**		
65.	**MINUTES OF PREVIOUS MEETING**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 29th June 2021 [Paper No. NHSGGC(M)21/04]. On the motion of Mr Ian Ritchie, seconded by Mr John Matthews OBE, the minute of the meeting was approved and accepted as an accurate record, subject to the following amendments: Item 46 – Welcome and Apologies – Page 2, paragraph 3 Ms Rona Sweeney had submitted apologies for the meeting. **APPROVED**		
66.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Board considered the Rolling Action List [Paper No. 21/39]. The Board agreed to the closure of five actions from the Rolling Action List. In addition, the following matters were discussed: NHSGGC Board Meeting of 29th June 2021 [Paper No. NHSGGC(M)21/04] – Minute 53, Queen Elizabeth University Hospital and Royal Hospital for Children Update, Page 9, Paragraph 5 & 6 It was noted that Mr Steele had provided further information with regards to the internal wall panels and a further update on this was requested. As Mr Steele was unable to attend the meeting, Mrs Grant provided an overview of the current position. She advised that a significant amount of work was ongoing with Multiplex to address this, and whilst it was anticipated that the		

			ACTION BY
	outcome would likely be that the panels were removed, further discussion and work was required to review all of the options and develop a proposal for action. It was agreed that an update on this would be presented to Finance, Planning and Performance Committee meeting on 12th October 2021, with an update to the full Board at its meeting on 26th October 2021. In addition, further discussion on this topic would take place at the Board Seminar Session scheduled for 15th September 2021. A question was raised regarding the risks associated with this, and if this was captured on the Corporate Risk Register. Mr White confirmed that the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) ongoing works and maintenance were included on the Corporate Risk Register. In respect of this specific piece of work, he noted that, once the discussions with Multiplex had concluded and a course of action agreed, this would be updated on the Risk Register accordingly. He assured members that QEUH/RHC works were scrutinised in detail by both the Corporate Management Team and the Finance, Planning and Performance Committee. **NOTED**		Mr Steele
67.	**CHAIR'S REPORT**		
	Professor Brown had attended a number of meetings of the standing governance committees which had taken place since the last Board meeting, including, meetings of the Acute Services Committee; Remuneration Committee; Staff Governance Committee; and the Finance, Planning and Performance Committee. Professor Brown also met with Standing Committee Chairs and chaired the first meeting of the Moving Forward Together Advisory Board. Professor Brown also attended the Integration Joint Board (IJB) Chairs and Vice Chairs Network event, where he provided the group with an update on the NHS Scotland approach to Active Governance. He went on to note that he had chaired meetings of the NHS Scotland Corporate Governance Steering Group and the Global Citizenship Advisory Board. Additionally, two meetings with local MSPs and MPs had taken place, where, in addition to the usual update on the response to the COVID-19 pandemic, the Chief Executive and the Executive		

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	Directors provided the elected representatives with some insight into plans for remobilisation, recovery and reform. Professor Brown was very impressed by a recent visit to the Lighthouse Laboratory on the QEUH campus and noted how Professor Dame Anna Dominiczak and her team had converted a large part of the Teaching and Learning Centre into a state of the art laboratory. **NOTED**		
68.	**CHIEF EXECUTIVE'S REPORT**		
	Mrs Jane Grant, Chief Executive, provided an overview of activities since the last Board Meeting. She noted that, in addition to the meetings highlighted by the Chair, she had also met with the Cabinet Secretary and discussed the response to the COVID-19 pandemic; the COVID-19 Vaccination Programme; and the COVID-19 Test and Protect Service. She highlighted that significant work was underway in respect of Remobilisation Plan 4 (RMP4), as well as the ongoing work at QEUH/RHC. The first meeting of the Advice Assurance and Review Group (AARG) had taken place, and the second meeting of the Group had been scheduled to take place on 11th August 2021, however this had been postponed at the request of the Scottish Government. Mrs Grant went on to note progression of work in respect of internal performance reporting, following the recent Board Seminar Session, with key actions being considered. She assured members that work with the standing committee Chairs would be undertaken in preparation for the next cycle of standing committee meetings. Mrs Grant highlighted a recent visit by the Minister of the Cabinet Office, the Rt Hon Michael Gove MP, to the University of Glasgow. The visit was led by Professor Iain McInnes. Mrs Grant was pleased to note the appointment of an Interim Chief Officer, Inverclyde HSCP. Mr Allan Stevenson would assume the role, once formally appointed to the interim position by the Inverclyde IJB. Professor Brown thanked Mrs Grant for the update, and invited comments and questions from members, on any of the matters		

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	raised by the Chief Executive Report and the Chairs Report. There were no questions or comments raised. **NOTED**		
69.	**PATIENT STORY**		
	Dr Margaret McGuire, Nurse Director, introduced the Patient Story, which featured a video of Dr Lara Mitchell, Consultant, Department for Medicine for the Elderly, South Sector. Dr Mitchell described how the Frailty Team at QEUH, engaged with people who use the service to identify improvements to their care experience whilst in the Acute Receiving Unit – Area 4. Professor Brown thanked Dr McGuire for the presentation. He noted thanks on behalf of the Board to Dr Mitchell and the Frailty Team for the efforts to engage with people who use the service and identify ways to improve patient care experience. He invited comments and questions from members. It was acknowledged that the work described was focused on the Acute experience of patients, however a question was raised about the efforts being made to improve the care experience throughout the whole care pathway. Dr McGuire confirmed that, whilst this piece of work was specifically focused on the Acute care experience, she described the wide range of other initiatives that were underway in respect of the other elements of the pathway including care homes and community services. **NOTED**		
70.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 21/40] presented by the Director of Public Health, Professor Linda de Caestecker. The paper provided an update on the overall position in respect of the NHSGGC response to managing COVID-19. Professor de Caestecker provided an overview of the key elements of the report including the current COVID-19 activity within hospitals; Acute and HSCP updates; Care Homes; the Test and Protect Service; and the Vaccination Programme. She noted that whilst infection rates were stabilising, these were higher than had been experienced in any of the previous waves, however this had not transferred to the same levels of severity of		

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	illness and mortality, and it was likely that this was due to the success of the Vaccination Programme and uptake. As of today, there were eight patients currently in Intensive Treatment Units (ITU) under 28 days, and 97 patients in hospital overall under 28 days. Whilst social distancing restrictions had been relaxed, 2 metre distancing in hospital remained in place. Self-isolation guidance had also changed, however there remained a significant workload for the Test and Protect Service, along with the Community Assessment Centres (CACs). Outbreaks in Care Homes had remained low, with a very small number of outbreaks, mainly associated with infections amongst staff. Professor de Caestecker went on to provide an overview of the Vaccination Programme, and highlighted the range of activities including drop-ins and a mobile bus, to increase vaccination uptake. More data was being obtained in respect of the impact of long COVID-19, and a research programme with the University of Glasgow was underway to consider the incidence and prevalence rates. Dr Emilia Crighton, Deputy Director of Public Health, went on to highlight the current statistics in respect of long COVID-19 prevalence; those most likely to be affected; and the most common symptoms displayed. Professor Brown thanked Professor de Caestecker and Dr Crighton for the update, and invited comments and questions from members. In response to a question regarding the Test and Protect Service, and if the Service had been augmented or adjusted during the response during the pandemic, to reflect fluctuations in the volume of workload or to improve efficiency, Professor de Caestecker described the changes made to the service to respond flexibly to the fluctuations in volume, which were done in collaboration with the national team. She noted the use of an automated system to handle contacts during periods of high volume. A question was raised regarding the proportion of staff within the Test and Protect Service that represent those who have been diverted to the Service from their substantive role and those who have been recruited specifically for that role. Professor de Caestecker noted that this had changed over time. At the inception of the service, most staff were those who had been reallocated from other roles, however now the majority of the staff		

			ACTION BY
	within the service were those who had been recruited specifically for that role. There remained some Health Improvement staff within the service, however plans were in place to reallocate these staff to their substantive posts in the coming weeks. In response to a question about the number of patients being treated for COVID-19 symptoms, versus the number of patient who had been admitted for other reasons but tested positive for COVID-19, Professor de Caestecker agreed to include this information in the next version of the report to be presented to the Board in October. A question was raised regarding the changes to restrictions for staff members in respect of COVID-19, and the option to "volunteer" to attend work and if this was likely to put increased pressure on staff. Professor de Caestecker noted that, prior to 9th August 2021, there was provision to allow staff to attend work, where services were particularly stretched, however this provision was not used in NHSGGC. Furthermore, Mrs MacPherson, Director of Human Resources and Organisational Development, assured members that this would involve a discussion with staff on an individual basis, to review the circumstances and the risks, to reach a mutual agreement, therefore it was suggested that perhaps "volunteer" was not the correct phrase to describe this. She highlighted the use of an internal checklist to ensure risk assessments were carried out, and that Lateral Flow testing was undertaken for 10 days. This was considered through Gold Command and Local Command to ensure appropriate steps taken on a case by case basis. In response to a question about plans in place to address the potential increase in cases, due to schools and universities returning, Professor de Caestecker advised that a significant amount of planning had been undertaken on a national basis. She highlighted the recent change in respect of guidance when infections were identified and noted that a nationally agreed letter had been drafted and this had been sent to all parents of school age children. Additionally, extensive work had taken place with universities, in order to prevent school children and university students from missing vital education due to COVID-19. A question was raised regarding the number of wards currently closed due to COVID-19. Mr Best, Chief Operating Officer, confirmed that there were currently 3 wards closed to admissions due to COVID-19, which was low compared to 22 wards closed during the peak of COVID-19. He assured members that point of care testing at front doors to hospitals was in place.		Prof de Caestecker

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	In response to a question regarding the levels of absence within the Acute Division, and how this was being managed, Mrs MacPherson highlighted that, prior to COVID-19, the absence rate for the organisation was approximately 5.2%, with this rising to approximately 6% during the winter season. For the period during the summer, the absence rate was at 6%. She reassured members that the rates of absence due to COVID-19 were small, given the size of the workforce. She assured members that this continued to be monitored closely. A question was raised regarding the plans in place for the winter flu vaccination programme, and if there was any further information in respect of a further COVID-19 booster vaccination. Professor de Caestecker advised that information on the requirement to undertake COVID-19 booster vaccinations was awaited. She noted that the seasonal flu vaccination programme would commence in early September 2021, with additional priority groups added including school teachers, prison staff and prisoners. Planning for this was well underway to ensure required resources were in place. Professor Brown thanked Professor de Caestecker and all teams currently undertaking work to respond to COVID-19. In summary, the Board were content to note the overall position in respect of the NHSGGC response to managing COVID-19 and were assured by the information provided. **NOTED**		
71.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'QEUH/RHC Update' [Paper No. 21/41] presented by the Chief Executive, Mrs Jane Grant. The paper provided an update on the position regarding the QEUH/RHC in respect of the Oversight Board and Case Note Review Report; the Public Inquiry; the Legal Claim; Ward 2a and 2b; and the Health and Safety Executive (HSE) Appeal. Mrs Grant noted that the second meeting of the AARG had been postponed at the request of Scottish Government and would now take place later this week. She assured members that a significant amount of work had been undertaken in respect of the Action Plan.		

			ACTION BY
	In respect of the Public Inquiry, evidential hearings would commence on Monday 20th September 2021, initially for three weeks. Members would have further opportunity to discuss this matter at the Board Seminar Session scheduled to take place on Wednesday 15th September 2021. In respect of the Legal Claim, Mrs Grant noted that hearings had taken place regarding the challenges submitted, led by Multiplex and Capita in respect of, whether there was a contractual requirement for both parties to adjudicate prior to raising the Court action; and; where the NHSGGC claim was within the five year time bar when it was lodged through Court action in January 2020. It was likely that the outcome of the hearing would not be known for eight to twelve weeks. Mrs Grant noted that work had progressed in respect of Ward 2a/2b, with the main contractor handover expected at the end of September 2021, with specialist commissioning completion in October 2021. Professor Brown thanked Mrs Grant for the update and invited comments and questions from members. In response to a question regarding the Action Plan referenced in paragraph 3.1.1 of the report, Mrs Grant provided an overview of the methods used to track progression of the actions, and would keep members up to date on this moving forward. A question was raised regarding the governance structure in place to oversee requests for information received by the Public Inquiry Project Management Office, and who the accountable officer was. Ms Vanhegan, Head of Corporate Governance and Administration assured the Board that there was a robust process established in respect of this. She highlighted that much of the requested information, was routine, however the Executive Oversight Group which met on a weekly basis, routinely reviewed and discussed requests received. In summary, the Board were content to note the report presented for assurance, and were assured by the information provided in respect of the key areas including the Oversight Board and Case Note Review Report; the Public Inquiry; the Legal Claim; Ward 2a/2b; and the HSE Appeal. **NOTED**		
72.	**NHSGGC INTEGRATED PERFORMANCE REPORT**		

			ACTION BY
	The Board considered the paper 'Performance Report' [Paper No. 21/42] presented by the Director of Finance, Mr Mark White. The report provided the Board with the performance against the key indicators outlined in the Remobilisation Plan 2, which covered the period 1st April 2021 to 31st July 2021. He highlighted that the key indicators had been presented to and considered by both the Acute Services Committee and the Finance, Planning and Performance Committee. Mr White highlighted the table contained within page 2 of the report which showed that, of the ten RMP3 indicators, six were rated green, with 4 rated red. He noted that new outpatient activity and the number of new outpatient referrals received, was exceeding trajectory by 2.3%. In respect of unscheduled care performance, the 4 hour target was being maintained and had exceeded the Scottish average. Professor Brown thanked Mr White for the update and invited comments and questions from members. In response to a question regarding the unscheduled care performance and what steps had been taken to improve performance, Mr Best assured members that a range of actions had been taken, however he noted that responding to COVID-19 remained along with the need to maintain red pathways. Planning for winter had been undertaken, and the redesign of unscheduled care was beginning to successfully divert people to self-care, and Minor Injures Units. Furthermore, the Mental Health Assessment Units (MHAUs) were working well, and overall the situation was improving. A question was raised regarding the current Child and Adolescent Mental Health Service (CAMHS) waiting times. Mrs Grant assured members that this was monitored closely at the Internal Performance Board. She assured members that the focus remained on urgent patients, along with longest waiting patients. Mrs Manion, offered further assurance that this remained a key focus across the Health and Social Care Partnerships (HSCPs), and was monitored closely by Chief Officers. Focus remained on the most urgent cases to ensure patient safety. In respect of a further question about the challenges associated with staff turnover, recruitment and retention, Mrs Manion confirmed that recruitment to CAMHS remained a national issue. She noted that in respect of staff turnover, this was due to movement of staff between HSCPs and promoted posts.		

			ACTION BY
	In response to a request for more historical trend data to be included in performance reports, Ms Vanhegan confirmed that, following the useful discussions at the recent Board Seminar Session, further work was underway as part of the Active Governance programme to review, the type of metrics used in performance reports, what was required and in which way this would be presented. A briefing had been circulated to standing committee Chairs in respect of this. A question was raised regarding the delay in respect of the building warrant required for the additional CT pod being located at the QEUH and why this was delayed. Mr Best confirmed that this was a paperwork issue. He highlighted that the CT pod was in place and ready to be used, and agreed to discuss this with Local Authority colleagues to expedite this. A question was raised in respect of the performance of unscheduled care, if the data presented was specifically in relation to Emergency Department (ED) and 4 hour targets, and if consideration was given to the wider pathways and Primary Care performance. Ms Lorna Kelly, Interim Director of Primary Care, provided an overview of the complexities in respect of this. She noted that there was not a single, agreed national data set for GP activity, however she noted that some data was received from GP practices and that she was very much involved in national work being progressed. Ms Kelly highlighted that an update on the Primary Care Implementation Plans (PCIPs) would be presented to the Finance, Planning and Performance Committee in October 2021, and also to the Board in October 2021. In response to a question regarding the impact assessment detailed on the cover report, and why this was rated as positive, given the current backlog in respect of Treatment Time Guarantee (TTG), Professor Brown advised that he had a discussion with Executive Directors regarding this, to ensure consistency going forward. In addition, Professor Brown was keen that a review of all papers would be undertaken at the end of the year, to review the number of papers presented for assurance, awareness, and approval, and how many were rated as having a positive, neutral or negative impact on the Boards Aims and Corporate Objectives. Further clarity was sought in respect of other Primary Care services, such as dental services and optometry. Mrs Grant confirmed that these were included within RMP3 and assured members that there was dedicated work in respect of other independent contractors.		Mr Best

			ACTION BY
	A question was raised regarding the psychological therapies measure, and why this had changed from green to red, since the report presented to the Finance, Planning and Performance Committee. Mrs Grant assured members that this had been discussed. She noted that the figure reported was in relation to the trajectory set within RMP3. However, overall performance was positive, albeit lower than trajectory. Mr White added that the figures presented did not include the full activity, and agreed to consider this issue for the next report to ensure this was clearer. In response to a question raised regarding delayed discharges related to Adults with Incapacity (AWI) and what actions were being taken to address this, Dr Margaret McGuire, Nurse Director, provided the Board with an overview of the main causes of this. She noted that there remained a substantial challenge in relation to the Court system within Glasgow. Additionally, the current legislation has caused challenges, and whilst there were views that the legislation required review and amendment, there were no plans to review this in the next eighteen months. Ms Caroline Sinclair, Interim Chief Officer, East Dunbartonshire HSCP, provided an overview of the actions being taken to address the variable margins, however highlighted that this was very complex. She assured members that every effort was being made to address the issues that could be influenced. In summary, the Board were content to note the performance against the key indicators outlined in the Remobilisation Plan 3, and were assured by the information provided that extensive work continued to address key areas to improve performance. **NOTED**		Mr White
73.	**NHSGGC REVENUE AND CAPITAL REPORT**		
	The Board considered the paper 'NHSGGC – Month 3 Finance Report' [Paper No. 21/43] presented by the Director of Finance, Mr Mark White. The paper provided an overview of the Month 3 Revenue position; the Month 3 Financial Improvement Programme (FIP) position; the Month 3 Capital position; and the 2021/22 Projection. The report had been scrutinised at the recent meeting of the Finance, Planning and Performance Committee. Mr White advised that, as at 30th June 2021, the Board's financial ledger highlighted an overspend of £35.9m, which was almost wholly attributable to unachieved savings.		

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	Mr White confirmed that the direct COVID-19 expenditure for the three months of the year had been covered by the initial allocations received from the Scottish Government, that being, £48.0m (£33.5 for the Board and £14.5m for IJBs) for direct expenditure on remobilisation and delivery of services due to COVID-19. In addition, unachieved savings due to the focus and effort on COVID-19 delivery of £16.9m (£15.6m related to the Board and £1.3m to the IJBs). The report also highlighted that the projected spend for the year had been submitted to the Scottish Government and totalled £290m. Mr White would continue to provide regular updates on the projected/actual spend as the year progressed. In respect of the Financial Improvement Programme (FIP), the Programme had been refreshed and remobilised this year. Mr White provided an overview of the current schemes, and the two-pronged approach to FIP this year, including a bottom up approach, and a top down approach for wider scale, strategic schemes. Mr White noted that, taking account of the current projection, level of risk and emerging pressures, the organisation was predicting a break even position at the year end. Professor Brown thanked Mr White for the update and invited comments and questions from members. In response to a question raised regarding the likely COVID-19 settlement from the Scottish Government and whether this would include unachieved savings, Mr White advised that this was still being considered by Scottish Government colleagues, however, he anticipated that the organisation would receive some contribution to unachieved savings. A question was raised about the final pay settlement for Agenda for Change pay grades. Mrs MacPherson confirmed that for Bands 1 – 4, this was a fixed amount of £1,009; Bands 5 – 7, a 4% increase; and for Bands above 7, a 2% increase was awarded. Mr White added that, as the pay deal entered years 3 and 4, it would be difficult to predict the financial impact, due to movement between Bands. In summary, the Board noted the report; noted the Month 3 Revenue position; the Month 3 Capital position; the Month 3 FIP position; and the Projection for 2021/22. The Board noted that the organisations ledger, as at 30th June 2021, recorded an overspend of £35.9m.		

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	NOTED		
74.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'The Healthcare Associated Infection Report for May and June 2021' [Paper No. 21/44] presented by the Executive Director for Infection Prevention and Control, Professor Angela Wallace. The paper provided an overview of the Healthcare Associated targets in respect of *Staphylococcus aureus bacteraemia* (SAB), *Clostridioides difficle* infections (CDI), and *E.coli bacteraemias (*ECB); incidents and outbreaks and all other healthcare associated infection activities across NHSGGC over the period of May and June 2021. Professor Wallace confirmed that the report would be presented to the Board as a bi-monthly report moving forward, with the full Healthcare Associated Infection Report Template (HAIRT) considered by the Clinical and Care Governance Committee on an ongoing basis. Professor Wallace highlighted that, for *Staphylococcus aureus bacteriaemias* (SAB), *Clostridioides difficle* infections (CDI), and *E.coli bacteraemias (*ECB) incidences, these were above aim, however remained within control limits. Professor Wallace assured the Board that there had been ongoing, sustained improvement in performance across NHSGGC. In respect of outbreaks detailed on page 7 of the report, Professor Wallace provided assurance that all Infection, Prevention and Control management processes had been applied. Where these required an IMT, Professor Wallace shared that Antimicrobial Resistence and Healthcare Associated Infection (ARHAI) have supported these processes. In respect of the estates position, Professor Wallace highlighted positive performance of cleanliness, responsiveness of estates intervention and the organisations hand hygiene performance. Professor Brown thanked Professor Wallace for the update and invited comments and questions from members. In response to a question about hospital acquired COVID-19 rates, Professor Wallace confirmed that this was included in the full HAIRT considered by the Clinical and Care Governance Committee. She highlighted that rates in NHSGGC were favourable in terms of the Scotland wide position.		

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	A question was raised regarding the escalation to Level 4 of the NHS Scotland Boards Performance Framework. Mrs Grant confirmed that the organisation remained at Level 4 of the framework in respect of infection prevention and control. She assured members that work continued and there was strong progress to deliver across the action points detailed within the Action Plan and that progress was presented to the AARG. In response to a question regarding the reported death due to hospital acquired CDI, and if there was any learning from this, Professor Wallace provided an overview of this incident, assured members that this was not an infection transmission issue. A question was raised regarding the outbreak reported in June, and if all actions had been taken. Professor Wallace assured members that all actions had been completed. Professor Wallace highlighted the significant work that had been undertaken in NHSGGC in respect of the IMT process. Professor Wallace shared the positive impact and learning that this work was making in respect to the IMT process. In summary, the Board noted the Healthcare Associated Infection Report; the performance in respect of the Annual Operational Plan (AOP) Standards for SAB, CDI, and ECB; the detailed activity in support of the prevention and control of Healthcare Associated Infection; and the contribution of the Infection Prevention and Control Team to NHSGGC response to COVID-19. **NOTED**		
75.	**REMOBILISATION PLAN 3 (RMP3) UPDATE**		
	The Board considered the paper 'Remobilisation Plan 3 (RMP3) Update' [Paper No. 21/45] presented by the Medical Director, Dr Jennifer Armstrong. The paper provided an update on remobilisation planning and implementation, and provided assurance of a robust project management approach to maintenance of RMP3. Dr Armstrong noted that RMP3 described how the health and social care system would remobilise in 2021/22. She noted that monthly progress reports were considered by the Strategic Executive Group (SEG) meeting, and exception reports were produced for areas where there were delays. The report described the high level overview of remobilisation commitments and activity for the first quarter of 2021/22.		

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	Dr Armstrong noted that the Scottish Government had requested a formal update of the plan by 30th September 2021 (RMP4) which would include revised activity projections. Professor Brown thanked Dr Armstrong for the update. He wished to note thanks on behalf of the Board to all of the teams who had contributed to the work. He invited comments and questions from members. In response to a question regarding the submission of the RMP4 update to Scottish Government, if this would include the Winter Plan, and if this could be presented to the Board in October, Mrs Grant confirmed that the submission would include the Winter Plan. She noted that authority from the Scottish Government was required before this could be published, therefore it was unlikely that the RMP4 would be available by the October Board meeting, however she agreed that a presentation would be provided at the October Board meeting on the key elements. A question was raise regarding the Mental Health Assessment Units (MHAUs), if these would be retained, and what the financial commitment was. Dr Armstrong confirmed that the MHAUs would remain in place. She noted that a financial framework had been established and that work continued to ensure longer term sustainability. Ms Susanne Millar, Chief Officer, Glasgow City HSCP, added that the MHAUs were set up as an immediate response to COVID-19. The initial model had a significant financial commitment, however this had since been brought in line with mental health funding. Additionally, establishment of MHAUs has now been mandated by the Scottish Government for NHS Scotland, and funding has been confirmed for these. In response to a question regarding remobilisation of services and if there were any services that had not been at least partially remobilised, Dr Armstrong confirmed that the vast majority of services had been fully, or partially remobilised. There were some services, for example Day Care which were more difficult to remobilise due to social distancing issues. Ms Millar further advised that there had been some challenges associated with Day Care services in the community, particularly in relation to transport to and from care centres, however this had been resolved using a hybrid or reduced model. A question was raised regarding the 440 actions included within RMP3, and if RMP4 provided an opportunity to refine or reduce these, or if it was anticipated that these would remain. Dr Armstrong confirmed that the targets and trajectories would be		Dr Armstrong

			ACTION BY
	considered by the teams. However teams across NHSGGC were focused on the delivery of NHSGGC remobilisation targets with plans to achieve the actions set out in RMP3. In response to a question regarding dental procedures undertaken in dental practices under private care, Ms Sinclair confirmed that this issue had been raised and was an ongoing, national issue. A question was raised regarding the remobilisation of podiatry and physiotherapy and if providing this digitally was considered as full remobilisation. Dr Armstrong advised that a blended model was in place. Virtual consultations had been used, along with face to face consultations where this was safe and appropriate to do so. Ms Beth Culshaw, Chief Officer, West Dunbartonshire HSCP, added that the use of technology had advanced within the field of Allied Health Professions, and work was ongoing in engaging with staff and service users, to measure satisfaction and outcomes. In response to a question regarding support to carers, Ms Millar advised that there was support for carers in place, and all HSCPs had developed outreach models to ensure support was provided in the community. In summary, the Board noted the RMP3 which outlined how the health and social care system would remobilise in 2021/22; that monthly progress reports were reviewed at the Strategic Executive Group meetings with exception reports produced where required; the commitments and activity for the first quarter of 2021/22; and that a formal update on the plan had been requested by Scottish Government by 30th September 2021 (RMP4). The Board would anticipate a presentation on RMP4, including the Winter Plan, to the October 2021 Board meeting. **NOTED**		Dr Armstrong
76.	**IMPLEMENTING THE ACTIVE GOVERNANCE APPROACH**		
	The Board considered the paper 'Implementing the Active Governance Approach in NHS Greater Glasgow and Clyde – Phase Two Update' [Paper No. 21/46] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration. The paper provided an update against Phase Two activities and one Phase One action. The paper also asked the Board to		

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	consider and approve the proposal to roll forward the operational priorities, agreed for the first quarter of the year to the full year. Ms Vanhegan provided an overview of the process undertaken to review the Corporate Risk Register, with standing committees reviewing their allocated risks, and the final document presented to the Board in October 2021. Additionally, the recent Board Seminar Session provided an opportunity to discuss and review the approach to risk, risk appetite and risk strategy. Useful feedback had been received from members in respect of this and the work on risk would be presented to the Audit and Risk Committee in September 2021, prior to presentation to the Board in October 2021. Ms Vanhegan outlined the operational priorities included within RMP3, which have subsequently been aligned to relevant committees and referenced within the Terms of Reference, as part of the annual review of committee terms of reference. She highlighted that this would also be presented to the Audit and Risk Committee in September 2021, prior to presentation to the Board in October 2021. Ms Vanhegan highlighted that work on the Corporate Objectives had progressed, and colleagues within the Communications Team were engaged in developing work to make these more visible across the full organisation. Professor Brown thanked Ms Vanhegan for the update and invited comments and questions from members. In response to a question regarding the governance of the eHealth Strategy, Ms Vanhegan confirmed that this was governed through the Finance, Planning and Performance Committee. A further question was then raised regarding the possibility to develop a Data Strategy, given the work to review the performance measures and data gaps. Mrs Grant advised that a full system review of performance measures and data was required, however she would be happy to discuss this further with Mr William Edwards, Director of eHealth and update the Board accordingly. In response to a question regarding the risk appetite, this being aligned to the orange book, and if benchmarking with other Boards would also be beneficial, Ms Vanhegan confirmed that benchmarking with other Boards had been undertaken to ascertain their approach to risk appetite. Mr White added that alignment to the orange book was suggested by members at the recent Board Seminar Session on risk. Additionally, the orange		Mrs Grant/ Mr Edwards

			ACTION BY
	book was the basis of Scottish Government risk management strategy. A question was raised regarding the direction of travel and linkages with national strategy, care programmes and workforce planning. Professor Brown responded that the MFT Programme formed the direction of travel and this includes the Clinical Strategy. Mrs Grant added that there were specific references to workforce planning within the operational priorities. Mrs MacPherson confirmed that Workforce Planning was carried out on an annual basis, and also formed a significant element of winter planning. In summary, the Board noted the report, and were content to approve the operational priorities were adopted for the year and that these would be aligned to personal objectives for performance appraisal purposes. **APPROVED**		
77.	**PUBLIC HEALTH SCREENING PROGRAMME ANNUNAL REPORT 2019/20**		
	The Board considered the paper 'Public Health Screening Report 2019-2020' [Paper No. 21/47] presented by the Deputy Director of Public Health, Dr Emilia Crighton. The paper was presented for assurance and included information about NHSGGC screening programmes for the period April 2019 to March 2020. Dr Crighton provided an overview of the screening programmes including, cervical screening; breast screening; bowel screening; pregnancy screening; newborn screening; pre-school vision screening; primary 7 school vision screening; diabetic retinopathy screening; and abdominal aortic aneurysm screening. Professor Brown thanked Dr Crighton for the update and thanked all teams across NHSGGC that deliver screening programmes. He invited comments and questions from members. In response to a question raised regarding the data contained within the report and if this was used to address health inequalities, Dr Crighton explained the way in which the data was captured. She highlighted that there was a wealth of data, and whilst this data was retrospective, there was live data and key performance indicators for specific performance and also for quality assurance. Each screening programme has a		

			ACTION BY
	corresponding National Programme Board, which validates the data, which was then presented to the Public Health Committee. Further discussion took place regarding the ways in which health inequalities could be addressed and Professor de Caestecker agreed that consideration would be given by the Public Health Committee as to what further actions could be taken to address this. In response to a question about obesity in pregnant women, and that incidences had increased on the previous year and what was being done to address this, Dr Crighton assured members that work was underway with universities in respect of research and identification of the most effective ways to address this. A question was raised regarding the data recorded for child vision screening. Dr Crighton explained that there was delay in producing the report due to schools being closed. Furthermore, the report covered the school year term, as opposed to the fiscal year. In summary, the Board noted the Public Health Annual Screening Report and noted the Adult Screening and Child and Maternal Health Key Performance Indicator against set targets. **NOTED**		Prof de Caestecker
78.	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**ACUTE SERVICES COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 20TH JULY 2021**		
	The Board were content to note the Chairs Report of the Acute Services Committee meeting held on 20th July 2021 [Paper No. 21/49]. A question was raised regarding the presentation provided by Dr Scott Davidson, Deputy Medical Director, on orthopaedic waiting times, specifically if these were not considered as Priority 1 and 2, then when would these be addressed. Mrs Grant confirmed that work had been undertaken to treat the Priority 1 groups, and that		

			ACTION BY
	work was now ongoing in respect of Priority 2 groups, and the longest waiters. She highlighted that recovery of the elective programme was a national issue which would take time to resolve, given the complexity of this. She assured members that every effort was being made to redesign services in order to address this. **NOTED**		
ii)	**MINUTE OF THE MEETING HELD ON 18TH MAY 2021**		
	The Board were content to note the approved minute of the Acute Services Committee meeting of 18th May 2021 [Paper No. ASC(M)21/01]. **NOTED**		
b)	**FINANCE PLANNING AND PERFORMANCE COMMITTEE**		
i)	**CHAIRS REPORT OF MEETING HELD ON 10TH AUGUST 2021**		
	The Board were content to note the Chairs Report of the Finance, Planning, and Performance Committee Meeting of 10th August 2021 [Paper No. 21/50]. **NOTED**		
ii)	**MINUTE OF THE MEETING HELD ON 15TH JUNE 2021**		
	The Board were content to note the approved minute of the Finance, Planning and Performance Committee Meeting of 15th June 2021 [Paper No. FPPC(M)21/02]. **NOTED**		
c)	**PUBLIC HEALTH COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 6TH JULY 2021**		
	The Board were content to note the Chairs Report of the Public Health Committee Meeting of 6th July 2021 [Paper No. 21/51]. **NOTED**		

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d)	**STAFF GOVERNANCE COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 3RD AUGUST 2021**		
	The Board were content to note the Chairs Report of the Staff Governance Committee Meeting of 3rd August 2021 [Paper No. 21/52]. **NOTED**		
ii)	**MINUTE OF THE MEETING HELD ON 11TH MAY 2021**		
	The Board were content to note the approved minute of the Staff Governance Committee Meeting of 11th May 2021 [Paper No. 21/02]. **NOTED**		
e)	**PHARMACY PRACTICES COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 21ST JULY 2021**		
	The Board were content to note the Chairs Report of the Pharmacy Practices Committee Meeting on 21st July 2021 [Paper No. 21/53]. NOTED		
ii)	**CHAIRS REPORT OF THE MEETING HELD ON 21ST JULY 2021 – SECTION 2 BUSINESS**		
	The Board were content to note the Chairs Report of the Pharmacy Practices Committee – Section 2 Business Meeting held on 21st July 2021 [Paper No. 21/54]. **NOTED**		

79.	**DATE AND TIME OF NEXT SCHEDULED MEETING**		
	The next meeting would be held on:		

	Special Board Meeting Tuesday 21st September 2021, 1:00pm, via MS Teams Board Meeting Tuesday 26th October 2021, 09:30am, via MS Teams		

NHS Greater Glasgow and Clyde	**Paper No. 21/41**
Meeting:	**NHS Board**
Meeting Date:	**17th August 2021**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager	**Chief Executive**
Report Author:	**Head of Corporate Governance**

1. Purpose

The purpose of the attached paper is to:

- Update the Finance Planning and Performance Committee on the positon regarding the Queen Elizabeth University Hospital and Royal Hospital for Children in respect of;
    - The Oversight Board and Case Note Review Report
    - The Public Inquiry.
    - The Legal Claim.
    - Ward 2a/2b.
    - The HSE Appeal.

2. Executive Summary

The paper can be summarised as follows:
The paper describes the significant activity which continues across all of the strands of work related to the QEUH/RHC.

3. Recommendations

There are no formal recommendations within the paper**.**

4. Response Required

This paper is presented for assurance.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- **Better Health** **Positive**
- **Better Care** **Positive**
- **Better Value** **Neutral**
- **Better Workplace** **Positive**
- **Equality & Diversity** **Neutral**
- **Environment** **Neutral**

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity: The issues described within the paper are subject to wide engagement across the organisation with each aspect led by a Corporate Director.

7. Governance Route

This paper has been previously considered by the following groups as part of its development: The issues described have been considered by the Executive Oversight Group, Chaired by the Chief Executive, and onwards to the Corporate Management Team, with regular Board updates.

8. Date Prepared & Issued

Prepared 10.08.21 Issued: 10.08.21

NHS Greater Glasgow & Clyde	**Paper No. 21/41**
Meeting:	**Board Meeting**
Meeting Date:	**17.08.21**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager	**Chief Executive**
Report Author:	**Head of Corporate Governance**

1. Introduction

This paper is presented to the Board to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided to the Board for the purposes of information and assurance.

2. Background

Board members will be familiar with the issues in respect of the QEUH and the RHC subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of Legal action against Multiplex, Currie and Brown and Capita, the Scottish Hospitals Public Inquiry and the ongoing HSE Appeal. This paper provides an update.

3. Assessment

3.1. Oversight Board

3.1.1 The Board received an update at the June meeting in respect of the Oversight Board Report and the Case Note Review Report, both published on 22nd March 2021. Significant progress has been made against the comprehensive action plan which was developed to ensure all the recommendations, including those of the External Review led by Drs Montgomery and Fraser, were being put in place to address the issues described in the reports. The work of the delivery group (Gold Command), chaired by the Chief Executive, continues to oversee progress against the action plan.

3.1.2 The second meeting of the Advice, Assurance and Review Group (AARG),

which replaced the Oversight Board structure, is scheduled for 11th August 2021.

3.2. Public Inquiry

3.2.1 The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. On 19th January 2021 Lord Brodie announced timescales for 2021 and on the 1st February 2021 issued core participants with formal evidence requests.

3.2.2 The first formal hearing of the Inquiry took place Tuesday 22nd June 2021. This was a a procedural hearing ahead of the first substantive hearings of the Inquiry which will commence on Monday 20th September 2021, initially set for three weeks, however will likely run on into the additional time set aside by the PI Team. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families and it is those patients and families who will form the core of those wishing to give evidence in person at the initial hearings.

3.2.3 The next set of hearings will focus Royal Hospital for Children and Young People in Edinburgh with hearings and are scheduled for May 2022.

3.2.4 Significant activity continues to respond to the first information request received on 1st February around the 3 priority areas noted below;

- A/ Adequacy of ventilation, water contamination and other matters adversely impacting on patient safety and care.
- B/ Governance and Project Management
- C/ Effects of the issues identified on patients and their families.

3.2.5 A number of meetings have been held with the dedicated team from the Central Legal Office and Inquiry Team Solicitors with documents now being transferred as requested in a coordinated manner. This is likely to continue for a number of months. In addition, and in preparation for the September hearing, meetings have also been scheduled with our Senior and Junior Counsels in the coming weeks.

3.2.6 The Programme Management Office (PMO) resources have been increased with a single Project Team being created to manage both the Legal Claim and the Inquiry in light of the significant cross over in terms of issues, management and information. The Executive Oversight Group, chaired by the Chief Executive and attended by key Directors, has increased the frequency of meetings to weekly to ensure effective and swift decision making takes place.

3.2.7 A Board Development Seminar has been scheduled for the 15th September to update the Board members ahead of the commencement of the first round of substantive hearings as described above.

3.3 ***Legal Claim***

3.3.1 The legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd. and Capita Property and Infrastructure Ltd. was lodged on 22 January 2020. Action was lodged with the Court for calling on

Monday 25th January 2021. The case has been remitted to the "Commercial Court". Hearings on preliminary points were heard on 26th February and 20th May 2021.

As previously highlighted to Board Members, there has been challenge led by the Multiplex and Capita in respect of;

- Whether it was a contractual requirement for both parties to adjudicate prior to raising the Court action – this is a feature of NEC 3 contracts;
- Whether the NHSGGC claim was within the five year time bar when lodged through court action in January 2020.

The legal debate in respect of the issues outlined above were heard on the 29th and 30th July 2021. Despite some negative media on the matter, the summary from our legal team remains positive in terms of success in the debate. It is likely that the outcome will not be known for 8-12 weeks. In the meantime work will continue in assessing the expert witness position in order to move forward in anticipation of a favourable outcome.

3.4 *Ward 2A/2B*

The engineering systems re-fit and refurbishment of wards 2A and 2B is nearing completion with the Main Contractor handover expected at the end of September with specialist commissioning completion into early October. A wider communications note will be issued nearer the time to patients, families and staff as well as other key stakeholders to ensure that the handover and transition happens seamlessly.

3.5 *HSE*

3.5.1 On 24th December 2019, the Health and Safety Executive (HSE) served on NHSGGC an Improvement Notice in relation to the ventilation system for Ward 4C. Legal advice was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

3.5.2 After an initial hearing relating to the Board's appeal against the HSE Improvement Notice, it was agreed that the legal representatives of the HSE and NHSGGC would meet. Due to COVID-19 there was a temporary suspension of activity. An initial hearing was held on 3rd September 2020 with a further preliminary hearing on the 23rd November 2020. The Court has provided a timeline for the appeal to proceed, with a further hearing scheduled for around October 2021. Dialogue continues with the CLO and Counsel with no further update at this stage.

4. Conclusions

Significant activity continues across all the strands of work related to the QEUH which is likely to increase even further in the coming months. The resource requirements of the senior leadership team and supporting elements, such as the PMO, remain under constant review. The senior team are clear of the priority that is required to ensure we respond effectively to the many requirements.

5. Recommendations

There are no specific recommendations.

6. Implementation

The position regarding the implementation of recommendations from the respective reports will be described in the accompanying presentation.

7. Evaluation

Not applicable at this stage.

8. Appendices

There are no appendices.

NHSGGC (M) 21/07
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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 26 October 2021 at 9.30 am via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Professor Iain McInnes CBE
Cllr Caroline Bamforth	Cllr Sheila Mechan
Ms Susan Brimelow OBE	Ms Ketki Miles
Mr Simon Carr	Cllr Iain Nicolson
Cllr Jim Clocherty	Mr Ian Ritchie
Mr Alan Cowan	Dr Lesley Rousselet
Professor Linda de Caestecker	Dr Paul Ryan
Mrs Jane Grant	Mr Francis Shennan
Mrs Margaret Kerr	Ms Rona Sweeney
Ms Amina Khan	Ms Flavia Tudoreanu
Rev John Matthews OBE	Mr Charles Vincent
Ms Dorothy McErlean	Ms Michelle Wailes
Dr Margaret McGuire	Mr Mark White

IN ATTENDANCE

Ms Lesley Aird		Assistant Director of Finance - Financial Services, Capital & Payroll
Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Mr William Edwards		Director of eHealth
Mrs Jennifer Haynes		Corporate Services Manager
Ms Lorna Kelly	..	Interim Director of Primary Care
Ms Christine Laverty	..	Interim Chief Officer Renfrewshire HSCP
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Mrs Geraldine Mathew	..	Secretariat Manager
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Julie Murray		Chief Officer, East Renfrewshire HSCP
Mr Tom Steele		Director of Estates and Facilities
Mr Allen Stevenson	..	Interim Chief Officer, Inverclyde HSCP
Ms Elaine Vanhegan	..	Head of Corporate Governance and Administration
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
89.	**WELCOME AND APOLOGIES**		
	Professor John Brown CBE, Chair, welcomed those present to the October 2021 meeting of the NHS Greater Glasgow and Clyde Board. The meeting combined members joining via video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were reminded to observe appropriate etiquette, and asked to ensure microphones remained on mute until invited to speak, use the virtual hands up function when wishing to contribute, and to refrain from using the chat function. Professor Brown welcomed members of the public who had taken up the invitation to attend the Board meeting, as observers, therefore the virtual hands up function should not be used by observers and they must remain on mute throughout the meeting. Professor Brown provided a brief overview of the key items of focus of today's meeting including Service Delivery; Remobilisation, including Winter Plan update; and Governance issues. The Chair highlighted that there were three late papers, those being: • Item 08 – Paper 21/61 - COVID-19 Update • Item 10 – Paper 21/63 – QEUH/RHC Update • Item 15 – Paper 21/68 – Implementing Active Governance Update Professor Brown asked Board members to confirm if they had any objections to accepting the late papers for consideration at today's meeting. Members were content to accept the late papers for consideration. Board member apologies were intimated on behalf of Cllr Jonathan McColl, Ms Jacqueline Forbes, Ms Anne Marie Monaghan, Cllr Mhairi Hunter, and Ms Paula Speirs. <u>NOTED</u>		

90.	**DECLARATIONS OF INTEREST**		
	The Chair invited members to declare any interests in any of the items being discussed. There were no declarations made. In addition, the Chair reminded all members of the requirement to keep their details on the Register of Interests up to date. Members were asked to please inform Ms Jennifer Haynes, and Professor Brown by email, should any of their details change. NOTED		
91.	**MINUTES OF PREVIOUS MEETING**		
a)	**MINUTE OF MEETING HELD 17 AUGUST 2021**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 17 August 2021 [Paper No. NHSGGC(M)21/05]. On the motion of Ms Flavia Tudoreanu, seconded by Cllr Sheila Mechan, the minute of the meeting was approved and accepted as an accurate and complete record. APPROVED		
b)	**MINUTE OF MEETING HELD 21 SEPTEMBER 2021**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde (NHSGGC) Board Meeting held on Tuesday 21 September 2021 [Paper No. NHSGGC(M)21/06]. On the motion of Cllr Sheila Mechan, seconded by Ms Margaret Kerr, the minute of the meeting was approved and accepted as an accurate and complete record. APPROVED		
92.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Board considered the paper 'Rolling Action List' [Paper No. 21/60]. The Board agreed to the closure of eight actions from the Rolling Action List. In addition, the following matter was discussed:		

	Minute 76 – Data Strategy It was highlighted that Ms Kerr had raised an issue in respect of this action, and it was agreed that this would be addressed as part of the Scheme of Delegation being discussed under Item 15 – Implementing the Active Governance Approach Update. APPROVED		
93.	**CHAIRS REPORT**		
	Professor Brown had attended a number of meetings which had taken place since the last Board meeting, including, five meetings of the Standing Governance Committees. He also met with the Standing Committee Chairs and had regular discussions with the Vice Chairs concerning a wide range of issues. In addition to attending the August and October Meetings of the NHS Scotland Chairs with the Cabinet Secretary, Professor Brown had been attending a weekly meeting with Mr Yousaf and the NHS Scotland Chairs and Chief Executives. All these meetings have been mainly focused on managing the current situation. Professor Brown had also attended four meetings of the NHS Scotland Board Chairs Group and two meetings with the West of Scotland Chairs. In addition to focussing on the current challenges faced by the NHS, these meetings discussed the Scottish Government's proposals for a National Care Service. These proposals were also the topic of a recent Board development session and an earlier meeting with the Chief Executive, and the NHS Leads on the six IJB that cover NHS Greater Glasgow and Clyde. Professor Brown also attended two meetings with the local MSPs and MPs where, in addition to the usual update on our response to the pandemic, Ms Grant and the Executive Directors provided the elected representatives with some insight into plans for supporting COP26. Ms Grant and Professor Brown also met with the Director of the NHS Scotland Test and Protect Programme recently, and discussed the next phase of the Test and Protect Strategy and how NHS Greater Glasgow and Clyde could assist in the ongoing fight against the Coronavirus. Professor Brown also hosted the official opening of the new Greenock Health and Care Centre by the Cabinet Secretary.		

	In addition, Professor Brown also chaired meetings of the NHS Scotland Corporate Governance Steering Group, the Global Citizenship Advisory Board, and a meeting of the Board of the Glasgow Centre for Population Health. Along with Professor Brown's NHS work, he also continued to contribute to the work of the RCPE Quality Governance Collaborative, the Advisory Board of the University of Dundee and the Board of Glasgow Life. NOTED		
94.	**CHIEF EXECUTIVES REPORT**		
	Mrs Jane Grant, Chief Executive, provided an overview of activities since the last Board Meeting. She noted that, in addition to the meetings highlighted by the Chair, she also attended a variety of meetings in respect of efforts to address the ongoing COVID-19 pandemic including the vaccination programme, testing and contact tracing. Significant work had also continued in respect of preparations for COP26. In addition, meetings with Central Legal Office (CLO) and Legal Counsel in respect of the Scottish Hospitals Public Inquiry and the ongoing legal claim had taken place. Mrs Grant also noted a meeting of the Advice, Assurance and Review Group (AARG) and good progress had been made in respect of the action plan. Considerable pressure remained in respect of emergency demand and urgent elective care, and focus continued on addressing this. Finally, Mrs Grant noted that, following a successful recruitment process, Mr Neil McCallum, had been appointed as the Director of North Sector. Professor Brown thanked Mrs Grant for the update and invited comments and questions from members, both on the Chief Executive update and the Chairs update. There were no questions raised. NOTED		
95.	**PATIENT STORY**		
	Dr Margaret McGuire, Nurse Director, introduced the Patient Story, which featured Ms Florence Dioka, a key individual in the African communities in Greater Glasgow and Clyde. The story described how NHS Greater Glasgow and Clyde made connections with the African communities to understand and		

	address barriers to uptake of COVID-19 vaccinations, and Ms Dioka provided her perspective on the COVID-19 pandemic, the effects on her community and both her involvement within NHSGGC and the organisations response. Professor Brown thanked Dr McGuire and noted special thanks to Ms Dioka for her contributions. He requested that the video be circulated by email to members. <u>NOTED</u>		**Secretary**
96.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 21/61] presented by Professor Linda de Caestecker, Director of Public Health. The paper provided an update on the overall position in respect of the NHS Greater Glasgow and Clyde response to managing COVID-19. Professor de Caestecker provided an overview of the current COVID-19 activity. She noted that the number of cases in NHSGGC had stabilised into an oscillating plateau pattern in recent weeks. Additionally, the number of COVID-19 cases in hospital, had begun to decline in recent weeks, however there remained a sustained and substantial level of COVID-19 related occupancy. As of 18 October 2021, there were 789 inpatients across all hospital sites, 275 inpatients within 28 days and 21 patients in ICU after testing positive for COVID-19. The winter vaccination programme had commenced and Professor de Caestecker highlighted the vaccinations being offered to specific groups including the seasonal flu vaccination and booster COVID-19 vaccinations. Discussions had taken place at the recent Population Health and Well Being Committee, regarding the vaccination programme. It was noted that, due to the current functionality of the IT system being provided by NHS National Services Scotland to deliver the vaccination programme, there was limited data available in respect of staff flu vaccination uptake rates. This remained a national issue, and work was underway to consider how more detailed information could be obtained for Health Boards. Professor Brown thanked Professor de Caestecker for the update and invited comments and questions from members. In response to a question regarding the length of stay in hospital for those with COVID-19, Professor de Caestecker described the complexities in respect of this. There had been a reduction in the length of stay in hospital, and that there were potentially a number		

	of reasons for this, specifically, that those being admitted were of a younger age than previously and more patients were vaccinated. In addition, more effective treatments were available which would also impact on the length of stay. Further information was requested in respect of the current sickness absence rates amongst staff. Mrs MacPherson confirmed that current absence rates were in line with the national position. She noted prevalence in respect of depression, stress and anxiety disorders and highlighted that HR Teams had been deployed to support managers. Additionally, the Occupational Health Team continued to support a cohort of staff with managing the impact of long COVID-19 related health issues. The Staff Governance Committee continued to monitor staff absence and actions taken to support staff and managers. A further question was raised in relation to staff absence and assurance sought about the speed of testing for staff isolating due to COVID-19. Professor de Caestecker assured members that test turnaround times continued to be very good. Additionally, she highlighted that the staff PCR testing service had been maintained, along with the general population testing system. In response to a question regarding the current number of hospital admissions for COVID-19 over 28 days, and what the reasons for this were, Professor de Caestecker assured members that the rate was reducing slowly, however she highlighted that this continued to be an oscillating plateau. Focus remained on encouraging the public to continue to be vigilant and ensure uptake of the COVID-19 vaccination. A question was raised about the impact of long COVID-19 and the likely impact of this on unscheduled care. Professor de Caestecker advised that extensive planning had been undertaken in relation to long COVID-19, and that this was being led by the Head of Allied Health Professionals (AHP), with consideration being given to how best to respond to this, self-help and self-care resources and specialist care for complex issues. She agreed to provide further information on this within the next report. In summary, the Board were content to note the report, and were assured by the information provided that significant effort continued in respect of all aspects of the organisations response to COVID-19. The Board noted the updates provided in respect of key areas including COVID-19 activity within hospitals; the Acute Division; Health and Social Care Partnerships (HSCPs); Care Homes; Test and Protect; and the Vaccination Programme. Professor Brown noted appreciation on behalf of the Board, to all of the teams and staff who continued to work tirelessly to respond to the ongoing challenges associated with COVID-19.		**Prof de Caestecker**

	NOTED		
97.	**PLANNING FOR COP26**		
	The Board considered the paper 'Planning for COP26' [Paper No. 21/62] presented by Professor Linda de Caestecker, Director of Public Health. The paper provided an overview of the ongoing planning for the forthcoming session of the Conference of Parties (COP26) to the United National Framework Convention on Climate Change. In addition to contributing to planning of the event itself, planning of the impact of the event on NHSGGC staff and services continued with involvement in the daily command control and coordination structure. Professor de Caestecker provided an overview of communications, training and capacity arrangements. Professor Brown thanked Professor de Caestecker for the update and invited comments and questions from members. In response to a question regarding arrangements for patient appointments and procedures, Mr Best advised that planning had been ongoing regarding this for some time, to ensure minimal disruption to patients and services. He noted a number of actions taken including increasing the number of virtual appointments available, and work with colleagues within the Scottish Ambulance Service (SAS) to ensure that crews allotted additional time for transporting patients to appointments. A question was raised regarding the likelihood of an increase in admissions. Mr Best explained that intelligence had been gathered from previous COP26 events. The greatest health requirements at previous events were minor ailment type issues and work had been undertaken to ensure Minor Injuries Units were fully utilised throughout this period, along with support from community pharmacy. Additional staff would also be available over the weekend of 6 and 7 November. In response to a question regarding input from voluntary first aid organisations, Mr Best confirmed that co-ordination of this had been done through SAS, and that arrangements were in place to provide a presence at demonstrations, where required. A question was raised about delegate requirements in respect of COVID-19. Professor de Caestecker advised that all delegates expected to be doubly vaccinated (though it was not a strict requirement) with support to those for whom it was difficult to access vaccination. PCR tests were also required at specific		

	times following entry to the country, along with daily LFT testing, wearing of masks and adhering to one metre social distancing. In respect of protestors attending, extensive messaging had been undertaken to reinforce the importance of LFT testing before they arrive as well as test kits being made available in a range of pick up points including community pharmacies and hotels. Additional PCR testing sites and arrangements for visitors to self-isolate had been put in place, and communications to organisers of protests had resulted in positive engagement and a commitment to making protests COVID-19 safe. In response to a question about modelling of the likely impact of the COP26 event on COVID-19 rates, Professor de Caestecker confirmed that this was being undertaken by the national team. In addition, local monitoring of real time data in terms of admissions would also be conducted. A question was raised regarding the remobilisation of beds and concerns raised about Day Surgery Units in Victoria ACH and Stobhill ACH, and whether these would be closed to increase bed availability for unscheduled care. Mr Best assured members that there were no plans to redeploy day surgery beds, and that current activity would continue. In summary, the Board were content to note the planning underway, and were assured by the information provided in respect of the actions taken to minimise the impact of COP26. Professor Brown wished to note thanks on behalf of the Board, to Professor de Caestecker and all staff who had contributed to planning and preparation for COP26. <u>NOTED</u>		
98.	**QEUH/RHC UPDATE**		
	The Board considered the paper 'QEUH/RHC Update' [Paper No. 21/63] presented by Mr Tom Steele, Director of Estates and Facilities. The paper provided an overview of the position regarding the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) in respect of:- • The Oversight Board and Case Note Review Report; • The Scottish Hospitals Public Inquiry; • The Legal Claim; • The Rectification Programme; • Ward 2a/2b; • The HSE Appeal.		

	Mr Steele noted that work continued in respect of the action plans following the report by the Oversight Board, which were 95% complete. Scrutiny of the 5% outstanding actions continued. The Scottish Hospital Public Inquiry evidence hearings resumed on 25 October, following a two week break. In respect of the Legal Claim, a written decision from Lord Tyre on the recent hearing on the matter of interrupted time bar, was awaited. Mr Steele provided an overview of the Rectification Programme of remedial works to rectify technical issues that were the subject of the legal claim, the costs of which would initially be met by the Scottish Government, with any recovery achieved transferred to Scottish Government Health Department. A Principal Supply Chain Partner (PSCP) for all remedial works had been appointed along with independent Cost Advisors and Project Managers to administer the contract on behalf of NHSGGC. Mr Steele noted that a decant ward may be needed to provide vacant access for works on a rolling programme. In respect of Ward 2a/2b, Mr Steele noted that significant remedial work to provide HEPA filtered environmental conditions suitable for use by immune-compromised patients including positive pressure single bedrooms and en-suite facilities was nearing completion. Works were scheduled for completion on 6 October, however due to issues with the resistance testing of the new terminal in-room HEPA filters, this had been delayed. The product manufacturer and the Board's Technical Advisors were engaged in product quality assurance. As soon as this was rectified, and appropriate checks, testing and sampling had been undertaken, the ward would be ready for occupation. Mr Steele noted that the Health and Safety Executive (HSE) have advised in writing that they were satisfied that the actions taken by the organisation as indicated in their Notification of Contravention issued in 2019 were complied with and the matter closed. This improvements made to Adult ITU and PICU which have resulted in the ventilation system being brought in line with SHTM03-01 as far as was reasonably practicable. The appeal against the Improvement Notice issued in 2019 regarding 4c was still outstanding. Expert reports were due to be submitted by both parties. The HSE have asked for a further extension prior to submitting their report. Discussion was underway with the Executive Team regarding timescales of the case overall. Professor Brown thanked Mr Steele for the update and invited comments and questions from members.		

	In response to a question regarding section 3.1.1 of the report and the outstanding actions, Mrs Grant confirmed that these were very small in number. None of the actions were critical, and three of the actions remained in discussion with Scottish Government. It was agreed that a further update on the outstanding actions would be provided to the next Finance, Planning and Performance Committee meeting in December, should these remain outstanding. A question was raised about the costs associated with the rectification works. Mr Steele assured members that there remained significant oversight of the costs. Greater confidence in relation to the costs and the funding awarded for these would be obtained in the coming weeks. Mr White confirmed that he remained comfortable with the current position. In response to a question about the Advice Assurance and Review Group (AARG) and if the organisation remained at Level Four of the NHS Scotland Performance Management Framework, Mrs Grant confirmed that, whilst the organisation remained at Level Four, discussions with Scottish Government continued in respect of the progress made and the outstanding actions. It was anticipated that formal communication from the Scottish Government would be received on the position in relation to escalation by the end of the year. A question was raised regarding the Atrium walls and further detail was sought. Mr Steele advised that all of the wall linings would be replaced in the atrium of the QEUH. Contractors had been on site in the last two weeks to consider how this could be achieved. It was estimated to take approximately 46 weeks from commencement of the works to completion. There were complexities in respect of limitations of numbers of trade staff in the area at any one time, and the requirement to maintain ongoing public access. In response to a question regarding input from the Microbiology Team in relation to Ward 2a/2b works and when the Ward would be reopened, Mr Steele confirmed that there was significant input from Microbiology colleagues, with Infection Control Doctors and Infection Control Nurses also involved. There was significant expert support and advice in respect of both ventilation and water systems. Once the issue had been resolved in respect of the HEPA filters, extensive testing and sampling would be undertaken and the Ward would be ready for reoccupation once all certification was completed. The Board were assured that a cautious approach would be taken to ensure extensive testing and assurances were received prior to any reoccupation of the Ward.		**Mr Steele**

	In summary, the Board were content to note the significant activity which continued across all of the strands of work related to the QEUH/RHC and Professor Brown thanked Mr Steele and all teams and staff involved in all aspects of the key elements reported. NOTED		
99.	**NHSGGC BOARD PERFORMANCE REPORT**		
	The Board considered the paper 'NHSGGC Board Performance Report' [Paper No. 21/64] presented by the Director of Finance, Mr Mark White. The paper provided an overview of performance against the key indicators outlined in the Remobilisation Plan 3 (RMP3), which covered 1 April 2021 to 30 September 2021. Mr White highlighted that performance against the key indicators had been extensively scrutinised by both the Acute Services Committee and the Finance, Planning and Performance Committee. Of the ten indicators, six indicators were reported as green and four indicators were reported as red. Performance reflected the ongoing requirement to respond to continued COVID-19 challenges. Mr White explained the requirement to submit Remobilisation Plan 4 (RMP4) and the Winter Plan to the Scottish Government by 30 September 2021. Formal feedback was awaited on both RMP4 and the Winter Plan from Scottish Government, and once this had been received, these would form the basis of the indicators for Performance Reports, moving forward. Professor Brown thanked Mr White for the update and invited comments and questions from members. In response to a question about the Children and Young People Mental Health Service (CAMHS) performance, which had declined since the last report, Mrs Grant assured members that significant work was underway to improve performance. Regular performance meetings with Health and Social Care Partnership (HSCP) Chief Officers and the Director of Finance continued to address this priority. Recruitment in some areas continued to be a challenge, and consideration was being given to different models, ways to improve recruitment, and how resource could be distributed across HSCPs to target areas experiencing difficulties. A significant amount of work was in progress, however it was acknowledged that the demand profile continued to grow, along with an increasing number of urgent cases, therefore, whilst some success had been achieved in reducing the longest waits, challenges remained due to increasing demand.		

	A further question was raised about the Integration Joint Board (IJBs) oversight and scrutiny of performance, and Ms Susanne Millar, Chief Officer, Glasgow City HSCP, assured the Board that this remained a key area of focus across all HSCPs and all HSCPs were fully engaged in partnership working to improve the position. Furthermore, Glasgow City IJB would consider a detailed paper on this issue at its next meeting on Monday 1 November, therefore the Board were assured of IJB oversight and scrutiny. In response to a question raised about the mitigating actions being taken, and when these were likely to result in an improvement in performance, Ms Millar assured members that the mitigations being implemented had resulted in improvements already, however rising demand had impacted this. She highlighted that a Performance Monitoring Group had been established and continued to redirect resource to the areas of greatest need. The Board were content to note the performance across NHSGGC in relation to the Key Performance Indicators (KPIs) outlined in RMP3. Professor Brown noted thanks on behalf of the Board, to Mr White, Mrs Grant, Ms Millar, and all teams and staff for their efforts, and recognised the significant amount of work in relation to improving performance in all areas. <u>NOTED</u>		
100.	**NHSGGC REVENUE AND CAPITAL REPORT**		
	The Board considered the paper 'NHSGGC – Month 5 Finance Report' [Paper No. 21/65] presented by the Director of Finance, Mr Mark White. The paper provided an overview of the Month 5 financial position, including the position of the Financial Improvement Programme (FIP) and the forecast for COVID-19 expenditure for 2021/22. Mr White highlighted that the report had been fully scrutinised by the Finance, Planning and Performance Committee at its recent meeting on 12 October 2021. Mr White noted that, as at 31 August 2021, the Board's financial ledger recorded overspend of £41.4m, which was wholly attributable to unachieved savings. He noted that direct expenditure on remobilisation and delivery of services due to COVID-19 was £61.6m (£56.1m for the Board and £5.5m for the Health costs within the IJBs), and this had been covered by the initial allocations received from the Scottish Government.		

	Mr White went on to note the COVID-19 spend total projection of £289.3m, split between £214.6m for the Board and £74.4m for the IJBs. It was anticipated that all COVID-19 expenditure would be met, however discussions remained ongoing with Scottish Government in respect of reimbursement of unachieved savings. <u>Financial Improvement Programme</u> On a full year basis, the Financial Improvement Programme has achieved £11.1m as at August 2021. There were 250 live projects and it was anticipated that the Programme would achieve a total of £30m at the end of the year, which represented 70% of the overall target. In summary, Mr White noted that, despite the potential gap of £20m increasing to £25.8m due to additional pressures associated with the AFC pay award and final uplift agreement and increased cost pressures from Office 365, current projections indicate financial break-even in-year was achievable. Professor Brown thanked Mr White for the update and invited comments and questions from members. In response to a question regarding the financial impact of preparations related to COP26, Mr White advised that a return had been submitted to the UK Government in respect of costs associated with COP26, with all costs being covered. The Board noted the revenue position at Month 5; the Month 5 position with the FIP; and the capital position at Month 5. Professor Brown thanked Mr White, the Finance Team, and all staff for their efforts to maintain financial balance despite the ongoing challenges. <u>NOTED</u>		
101.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Reporting Template (HAIRT) for July and August 2021' [Paper No. 21/66] presented by Professor Angela Wallace, Executive Director for Infection Prevention and Control. The paper provided an overview of the Healthcare Associated targets in respect of *Staphylococcus aureus bacteraemia* (SAB), *Clostridioides difficile infections* (CDI), and *E.coli bacteraemias*; incidents and outbreaks and all other healthcare associated infection activities across NHSGGC over the period of July and August 2021.		

	Professor Wallace confirmed that *Staphylococcus aureus bacteraemia* (SAB), *Clostridioides difficle infections* (CDI), and *E.coli bacteraemias*; incidences, all remained within control limits. Professor Wallace noted that there remained ongoing, sustained improvement within NHSGCC. Professor Wallace noted the Quarterly Report of Antimicrobial Resistance and Healthcare Associated Infection (ARHAI) Scotland. The data provided within the ARHAI Report demonstrated that NHSGGC were not outliers in any category presented and the charts within the report clearly highlighted continuous improvement over time. As a result of the improvement work within NHSGGC, the organisation had been asked to contribute to examples of best practice and sharing of learning across NHS Scotland Boards. Collaborative working with eHealth colleagues had been undertaken to incorporate several measures into the MicroStrategy dashboard. Professor Wallace noted thanks to Mr William Edwards, Director of eHealth, the eHealth Team, and all staff who had contributed to the development of this unique tool. Professor Brown thanked Professor Wallace and invited comments and questions from members. In response to a question regarding the sustained improvements made in respect of Infection Prevention and Control and the ongoing escalation to Level Four of the NHS Scotland Boards Performance Framework, Mrs Grant highlighted that she, and the Board Chair, would shortly meet with Scottish Government colleagues to discuss this issue further. A question was raised regarding ward closures due to COVID-19, and the reported increase from July to August, and what the current position was. Professor Wallace confirmed that there were currently eight wards closed across NHSGGC. She assured members that the Infection Prevention and Control Teams and Operational Managers continued to work extremely hard to ensure safety and continuity of service. Mr Best added that the majority of wards closed were due to COVID-19. He noted that one ward was closed currently due to a norovirus outbreak. He assured members that daily meetings took place at each site with ward closures to ensure this was managed effectively. A question was raised regarding the decision making process undertaken when closing a ward due to infection and whether staff were considered and tested as part of this process. Professor Wallace confirmed that both patients and staff were tested as part of any response to any potential infection outbreak.		

	In response to a question about incidences of wards closed due to the redeployment of staff and if this information was included, Mrs Grant confirmed that there had been a reduction of the elective programme because of the emergency demand, therefore some surgical wards had received medical patients. This was the position across other NHS Boards. Mr Best added that the organisation was required to report formally on the closure of wards due to infection, however he assured members that there were processes in place in respect of the redeployment of staff and this was recorded via the performance reporting mechanism. In summary, the Board were content to note the HAIRT report; the performance in respect of the Annual Operational Plan (AOP) Standards for SAB, CDI, and ECB; the detailed activity in support of the prevention and control of Healthcare Associated Infections; and the contribution of the infection Prevention and Control Team (IPCT) to the organisations response to COVID-19. Professor Brown thanked Professor Wallace, the IPCT, and all teams and staff for their contributions to achieving an ongoing, sustained improvement in respect of healthcare associated infections. <u>NOTED</u>		
102.	**REMOBILISATION PLAN 4 AND WINTER PLAN UPDATE**		
	The Board considered the paper 'Remobilisation Plan 4 and Winter Plan Update' [Paper No. 21/67] presented by the Medical Director, Dr Jennifer Armstrong. The paper provided an update on the current remobilisation position and the preparations and plans developed for winter 2021/22. Dr Armstrong highlighted that a presentation had been provided to the Finance, Planning and Performance Committee, at its recent meeting of 12 October 2021. Dr Armstrong provided an overview of the key elements of RMP4 including staff health and wellbeing; the elective programme; critical care; primary care; mental health; digital programmes; sustainability/green agenda; and finance. Dr Armstrong went on to provide an overview of the key elements of the Winter Plan 2021/22, including primary care; redesign of urgent care; secondary care; children; community services; and mental health. Professor Brown thanked Dr Armstrong for the update and invited comments and questions from members.		

	In response to a question regarding public messaging and redirection policy, Dr Armstrong advised that there were three elements in respect of this. She highlighted the extensive work being undertaken to direct patients to the right place of care, to ensure they accessed the most appropriate service. Furthermore, signposting at Emergency Departments (EDs) was being undertaken by dedicated nurses, and this would be further strengthened by a redirection policy to allow clinicians to redirect individuals to more appropriate care. This work was being done on a national basis, therefore implementation would be done in tandem with all NHS Scotland Boards. Mrs Grant added thanks on behalf of the Board to Dr Scott Davidson and his Team for their efforts over the weekend to signpost patients and encourage use of the most appropriate services to reduce inappropriate attendances at EDs. A question was raised about efforts to continue communications and reassurance to the public, given the current pause of elective programmes. Mr Best assured members that the Outpatient Referral Management Centres had undertaken extensive work to contact patients regularly to advise them of the current position. Patients were reminded at every opportunity, that should their condition worsen, then they should contact their GP immediately. In response to a question about peer support programmes, and the current position in respect of this, Dr Armstrong advised that external training had been obtained and approximately thirty consultants had been trained to act as peer supporters. Mrs MacPherson added that early discussions had taken place regarding the peer support programme, and the model of best practice. Significant stakeholder input was acquired and a model for all staff was being developed. The Board were content to note the revised planning assumptions and service changes since the submission of RMP4; and the preparations and plans developed for the Winter Plan 2021/22. The Board would anticipate a further update on this at the next meeting of the Board in December 2021. <u>NOTED</u>		**Dr Armstrong**
103.	**IMPLEMENTING THE ACTIVE GOVERNANCE APPROACH UPDATE**		
	The Board considered the paper ‘Implementing the Active Governance Approach Update’ [Paper No. 21/68] presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The paper provided an update on implementation of the Active Governance approach in NHSGGC.		

	Ms Vanhegan noted progress in respect of the Active Governance Programme actions and highlighted that the actions in respect of risk, had been completed and were included as a separate item on the agenda for today's meeting. Ms Vanhegan noted the further work undertaken on the Scheme of Delegation and highlighted that this had been included within the paper. Professor Brown thanked Ms Vanhegan for the update and invited comments and questions from members. In response to a question regarding the governance of whistleblowing and this being overseen by the Audit and Risk Committee without input from the Staff Governance Committee, Professor Brown advised that discussion regarding this took place at the recent Audit and Risk Committee meeting, specifically in relation to the range of issues raised by whistleblowing. This could represent a very wide range with many of these issues not specifically related to staff issues. Oversight by the Staff Governance Committee reflects a false assumption that the majority of the matters raised were related specifically to staff issues. Furthermore, significant effort had been made whilst reviewing the Scheme of Delegation to ensure minimal duplication of scrutiny by Standing Committees. Mr Charles Vincent highlighted that he was supportive of whistleblowing being overseen by the Audit and Risk Committee, however he acknowledged that there were potentially some staffing issues which arose from whistleblowing cases. In particular, the oversight of the protection and treatment of whistle-blowers remained a fundamental component of the whistleblowing process. Following discussion, it was agreed that the Audit and Risk Committee would receive the Quarterly and Annual Whistleblowing Reports, with the Board receiving the Annual Report. In addition, the Staff Governance Committee would also receive the Annual Report for consideration of any staff matters raised, including the support received by whistleblowers. A question was raised about the timescales for resuming Board Member Visits. Mrs Grant explained that the current ongoing positon in respect of COVID-19 made this particularly challenging, along with the ongoing demand challenges and additional work associated with the visit programme, therefore it was anticipated that the programme would resume in Spring 2022 at the earliest. In response to a question about the Corporate Statements and if these had been updated on the website, Ms Sandra Bustillo confirmed that work was underway to improve the visibility of the Corporate Statements, both on the website and through		

	communications with staff. A new website was currently being developed by the Web Development Team and prominence would be given to the Corporate Statements on this. A question was raised regarding the oversight of operational risk management. Following discussion, it was agreed that the Audit and Risk Committee would provide oversight of operational risk management issues. In summary, the Board were assured as to the position with the Active Governance Programme; approved the Scheme of Delegation and acknowledged any revisions to supporting documentation would be undertaken; approved the Board Calendar for 2022/23; approved the updated version of Board Member Responsibilities; noted the Board's Annual Cycle of Business for 2021/22; approved the approach to the development of a Board visiting programme; approved the revised approach to the Board Agenda format; and noted the rationale behind the changes to the Scheme of Delegation in relation to Whistleblowing. Professor Brown noted thanks on behalf of the Board to Ms Vanhegan and team for their efforts to provide a comprehensive overview of implementation of the active governance approach. <u>APPROVED</u>		
104.	**RISK MANAGEMENT**		
a)	**CORPORATE RISK REGISTER**		
	The Board considered the paper 'Corporate Risk Register' [Paper No. 21/69a] presented by Mr Mark White, Director of Finance. The paper provided an update on, and assurance of, the current Corporate Risk Register, noting that this had been reviewed by senior management, and the relevant standing committees. Following discussion at the recent Acute Services Committee, it was agreed that scheduled and unscheduled care would be recorded separately, and the updated Corporate Risk Register would be presented for consideration to the next Audit and Risk Committee meeting. Professor Brown thanked Mr White and invited comments and questions from members. In response to a comment about risks remaining high despite mitigations, Mr White agreed to incorporate explanation regarding this in the next iteration of the report.		**Mr White** **Mr White**

	A question was raised regarding the oversight of allocated risks by individual standing committees. Professor Brown clarified that it was intended going forward, that each standing committee carried out an in-depth scrutiny of one of their allocated risks at each meeting, with the Board then reviewing the Corporate Risk Register on a bi-annual basis. In response to a question regarding the risks associated with tackling waiting list initiatives, specifically funding available in respect of this, Mr White explained that this issue remained under scrutiny and continued to be debated. He highlighted that this was not necessarily an issue in respect of the financial implications, more so related to the availability of staff to increase productivity. A suggestion was made in relation to the description of risks and that these should include, where possible, the cause and impact within the description. Furthermore, some gaps were highlighted including the following risk areas:- • The loss of members of the corporate management team; • The ineffective use of medicines – further clarity was sought in respect of timescales for reviews; • The implementation of the Public Protection Strategy – further clarity was sought in respect of timescales; • The delivery of urgent care out of hours – required to be added to the risks; • Where there was no change to the impact or likelihood of a risk, assurance was sought that actions had been taken to identify any other mitigations. In summary, the Board were content to note the ongoing work of the Audit and Risk Committee and other standing committees in scrutinising, reviewing and updating their risk registers and took assurance from that process; reviewed and accepted the updated overarching Corporate Risk Register, subject to any changes or feedback to relevant standing committees as agreed. <u>NOTED</u>		**Mr White**
b)	**RISK APPETITE STATEMENT**		
	The Board considered the paper 'Risk Management – Risk Appetite Statement' [Paper No. 21/69b] presented by Mr Mark White, Director of Finance. The paper described the work undertaken to develop a Risk Appetite Statement to clarify the Board's position and articulate its views on risks. The Risk Appetite Statement formed a key element of the risk management arrangements.		

	Mr White noted that development of the Risk Management System remained in progress. He highlighted work undertaken to review processes and mapping of additional areas of risk, and that this would be updated as the process moved through the stages. The next stage of the process would be to align departmental risks. Mr White noted the appointment of a Senior Risk Officer to strengthen the position and to assist standing committees in their scrutiny of risk. Professor Brown thanked Mr White for the update and invited comments and questions from members. There were no questions raised. In summary, the Board were content to note the work that had been undertaken to develop the Risk Appetite Statement; the ongoing annual review process; and approved the enclosed updated Risk Appetite Statement as recommended by the working group. Professor Brown thanked Mr White, his team, and all staff involved in developing this important work. <u>APPROVED</u>		
105.	**NHSGGC CLINICAL AND CARE GOVERNANCE ANNUAL REPORT 2020/2021**		
	The Board considered the paper 'NHSGGC Clinical and Care Governance Annual Report 2020/21' [Paper No. 21/70] presented by Dr Jennifer Armstrong, Medical Director. The paper described the clinical governance arrangements, and progress made in improving safe, effective, and person centred care. It detailed a small selection of the activities and interventions, therefore was illustrative rather than comprehensive and it was important to note that there was substantially more activity at clinician, team, and service level arising from the shared commitment to provide high quality of care. Professor Brown thanked Dr Armstrong for the update and invited comments and questions from members. There were no questions raised. The Board were content to note the Clinical and Care Governance Annual Report 2020/21, and Professor Brown noted thanks on behalf of the Board to Dr Armstrong, Ms Geraldine Jordan, and all teams and staff for their contributions to clinical governance and ensuring safe, effective, and person centred care. <u>NOTED</u>		

106.	**WHISTLEBLOWING ANNUAL REPORT**		
	The Board considered the paper 'Whistleblowing Annual Report' [Paper No. 21/71] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration. The paper provided an overview of whistleblowing activity from 2020/21 and offered assurance that whistleblowing investigations took place in line with the Whistleblowing Policy and that all preparatory work was undertaken to ensure that NHSGGC was compliant with the new National Whistleblowing Standards. Professor Brown thanked Ms Vanhegan for the update, and invited comments and questions from members. In response to a question regarding arrangements for home working, if there was information regarding the percentage of staff working from home, and if the Staff Governance Committee had considered this, Mrs MacPherson advised that there was currently no data on the percentage of staff home working, however she highlighted that through provisions made and work undertaken by Mr Edwards team, a significant number of staff had opportunity to undertake home working. In addition, a homeworking group had been established. Discussions were underway to develop a national policy, and there was currently local guidance supported by staff partnerships. The Board were content to note the performance from the year 2020/21; and the improvement work undertaken to make the whistleblowing service effective, supportive and fit for purpose. Professor Brown noted thanks on behalf of the Board to Ms Jennifer Haynes, Corporate Services Manager – Governance, for her significant efforts to implement the required amendments in respect of whistleblowing and for production of an excellent report. NOTED		
107.	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**ACUTE SERVICES COMMITTEE**		
i)	**CHAIRS REPORT OF MEETING HELD 21 SEPTEMBER 2021**		
	The Board were content to note the Chairs Report of the meeting held on 21 September 2021 [Paper No. 21/72]. NOTED		

ii)	**MINUTE OF THE MEETING HELD ON 20 JULY 2021**		
	The Board were content to note the minute of the meeting held on 20 July 2021 [Paper No. ASC(M)21/02]. NOTED		
b)	**FINANCE, PLANNING AND PERFORMANCE COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 12 OCTOBER 2021**		
	The Board were content to note the Chairs Report of the meeting held on 12 October 2021 [Paper No. 21/73]. NOTED		
ii)	**MINUTE OF THE MEETING HELD ON 10 AUGUST 2021**		
	The Board were content to note the minute of the meeting held on 10 August 2021 [Paper No. FPPC(M)21/03]. NOTED		
c)	**AUDIT AND RISK COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 14 SEPTEMBER 2021**		
	The Board were content to note the minute of the meeting held on 14 September 2021 [Paper No. 21/74]. NOTED		
ii)	**MINUTE OF THE MEETING HELD ON 16 MARCH 2021**		
	The Board were content to note the minute of the meeting held on 16 March 2021 [Paper No. ARC(M)21/01]. NOTED		
iii)	**MINUTE OF THE MEETING HELD ON 22 JUNE 2021**		
	The Board were content to note the minute of the meeting held on 22 June 2021 [Paper No. ARC(M)21/02]. NOTED		

d)	**CLINICAL AND CARE GOVERNANCE COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 14 SEPTEMBER 2021**		
	The Board were content to note the Chairs Report of the meeting held on 14 September 2021 [Paper No.21/75]. NOTED		
ii)	**MINUTE OF THE MEETING HELD ON 8 JUNE 2021**		
	The Board were content to note the minute of the meeting held on 8 June 2021 [Paper No. CCGC(M)21/01]. NOTED		
e)	**POPULATION HEALTH AND WELL BEING COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 13 OCTOBER 2021**		
	The Board were content to note the Chairs Report of the meeting held on 13 October 2021 [Paper No. 21/76]. NOTED		
ii)	**MINUTE OF THE MEETING HELD ON 6 JULY 2021**		
	The Board were content to note the minute of the meeting held on 6 July 2021 [Paper No. PHC(M)21/01]. NOTED		
f)	**AREA CLINICAL FORUM**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 12 AUGUST 2021**		
	The Board were content to note the Chairs Report of the meeting held on 12 August 2021 [Paper No. 21/77]. NOTED		
g)	**PHARMACY PRACTICES COMMITTEE**		
i)	**CHAIRS REPORT OF THE MEETING HELD ON 1 SEPTEMBER 2021**		

	The Board were content to note the Chairs Report of the meeting held on 1 September 2021 [Paper No. 21/78]. NOTED		
108.	**VALEDICTORY**		
	Professor Brown advised members that Ms Dorothy McErlean had notified the Board of her intention to retire in December 2021, as such this would be Ms McErlean's last meeting with the Board. Professor Brown wished to note thanks to Ms McErlean on behalf of the Board, for her dedication and commitment to the Board and the organisation over a number of years, not only as a Board member but also as a member of IJBs. Ms McErlean was an asset to the organisation and had successfully demonstrated a balance between her role as Employee Director and as a Board member. Ms McErlean's support and specialist advice on a wide range of issues would be missed. Professor Brown noted congratulations to Ms McErlean and wished her a long and happy retirement. NOTED		
109.	**FORMER DIRECTOR OF COMMUNICATIONS OF NHSGGC**		
	It was with sorrow that Professor Brown informed the Board of the recent passing of Mr Ally McLaws, the former Director of Communications within NHSGGC, following a long battle with cancer. Mr McLaws had written about his experiences of having the disease in the Sunday Herald and many Board members and staff within the organisation had continued to follow Mr McLaws journey through his column. Professor Brown noted appreciation for everything Mr McLaws brought to the Board over the years and the legacy he left within the organisation, and within the Communications and Engagement Team, enabling them to make a positive impact on the health and wellbeing of the people of Greater Glasgow and Clyde. Mr McLaws would be sorely missed, and Professor Brown and Board members thoughts were with his family at this very sad time.		
110.	**DATE AND TIME OF NEXT SCHEDULED MEETING**		
	The next meeting would be held on Tuesday 21 December 2021, at 9.30 am, via MS Teams.		

NHS Greater Glasgow & Clyde	**Paper No. 21/63**
Meeting:	**Board Meeting**
Date of Meeting:	**26 October 2021**
Title:	**QEUH / RHC Update**
Sponsoring Director/Manager:	**Tom Steele Director of Estates and Facilities**
Report Author:	**Tom Steele Director of Estates and Facilities**

1. Purpose

The purpose of the attached paper is to:

Update the NHS GGC Board Meeting on the positon regarding the Queen Elizabeth University Hospital and Royal Hospital for Children in respect of;

- The Oversight Board and Case Note Review Report
- The Public Inquiry.
- The Legal Claim.
- The Rectification Programme
- Ward 2a/2b.
- The HSE Appeal.

2. Executive Summary

The paper describes the significant activity which continues across all of the strands of work related to the QEUH/RHC.

3. Recommendations

There are no formal recommendations within the paper.

4. Response Required

This paper is presented for assurance.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Better Health Positive
- Better Care Positive
- Better Value Neutral
- Better Workplace Positive
- Equality & Diversity Neutral
- Environment Positive

6. Engagement and Communication

The issues described within the paper are subject to wide engagement across the organisation with each aspect led by a Corporate Director.

7. Governance Route

This paper has been previously considered by the following groups as part of its development: The issues described have been considered by the Executive Oversight Group, Chaired by the Chief Executive, and onwards to the Corporate Management Team, with regular Board updates.

8. Date Prepared and Issued

Date Prepared: 01/10/21
Date Issued: 20/10/21

NHS Greater Glasgow & Clyde	**Paper No. 21/63**
Meeting:	**Board Meeting**
Date of Meeting:	**26 October 2021**
Title:	**QEUH / RHC Update**
Sponsoring Director/Manager:	**Tom Steele Director of Estates and Facilities**
Report Author:	**Tom Steele Director of Estates and Facilities**

1. Introduction

This paper is presented to the NHS GGC Board Meeting to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided to the Board for the purposes of information and assurance.

2. Background

Board members will be familiar with the issues in respect of the QEUH and the RHC subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of Legal action against Multiplex, Currie and Brown and Capita, the Scottish Hospitals Public Inquiry and the ongoing HSE Appeal. This paper provides an update.

3. Assessment

3.1 **Oversight Board**

3.1.1 Further to publication of the Oversight Board Report and the Case Note Review Report, a comprehensive action plan was developed to ensure all the recommendations, including those of the External Review led by Drs Montgomery and Fraser, were being put in place to address the issues described in the reports. The work of the delivery group (Gold Command), chaired by the Chief Executive, and has overseen progress against the action plan, with 95% of all actions now complete.

3.1.2 The significant progress made was acknowledged by the Advice, Assurance and Review Group (AARG), at the second meeting of this group held on the 19 August. Dialogue continues with the Scottish Government.

3.2. Public Inquiry

3.2.1 The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020.

3.2.2 The first substantive hearings of the Inquiry commenced on Monday 20 September 2021, running for 3 weeks until Thursday 7 October, with a 2 week break until recommencing on Monday 25 October for a further 2 weeks. The focus of this first set of hearings is to enable the Inquiry to understand the experiences of affected patients and their families. The Executive Oversight Group are identifying and reviewing themes across the evidence being given. At this stage in the process the Board is unable to respond in any way and we continue to co-operate fully with the Inquiry Team.

3.2.3 The next set of hearings will focus Royal Hospital for Children and Young People in Edinburgh with hearings and are scheduled for May 2022.

3.2.4 Meetings continue with the dedicated team from the Central Legal Office (CLO) and Inquiry Team Solicitors with documents now being transferred as requested in a coordinated manner.

3.2.5 Board members will have seen reference in the media announcements regarding a criminal investigation being established. The Board has not received any formal notification and our QC is seeking clarity on the overall position.

3.3 The Legal Claim

3.3.1 The legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd. and Capita Property and Infrastructure Ltd. was lodged on 22 January 2020. Action was lodged with the Court for calling on Monday 25 January 2021. The case has been remitted to the “Commercial Court”. On 28 and 29 July Lord Tyre heard the legal debate on the matter of interrupted time bar. A written decision from Lord Tyre is awaited. If the result of the debate is unsuccessful then alternate means of advancing the action will be an appeal to the inner house. Senior Counsel remains confident about the prospects of success.

3.3.2 Within the original summons the loss and damage was reasonably estimated to be £72.8m. A further £18.2m was stated in an additional summons with regard to the chilled water.

3.3.3 Prior to lodging the action in January 2021, MacRoberts LLP provided NHS GGC with legal advice notes on the prospects of success in relation to each of the claims in the Court Action. These notes incorporated preliminary expert reports by independent technical experts and indicated that there were grounds to continue across all heads of claim. There is regular exchange of information, review and decisions required to meet the defined timescale to prepare for the legal debate. Alternate means of dispute resolution are being explored.

3.4 QEUH/RHC Rectification Programme

3.4.1 In advance of any outcome from the legal cases, a programme of remedial works to rectify technical issues that are the subject of the claim, will be undertaken. The cost of these works will initially be met by the Scottish Government with any recovery achieved transferred to Scottish Government Health Department.

3.4.2 To date the Board has incurred costs as a result of reactive maintenance and repairs and some specific rectification or risk mitigation works. The main areas of work there are 14 heads of claim in the legal action. Full rectification of the technical issues is complex, requiring careful planning, phasing and diligent qualitative review of proposals. A Principal Supply Chain Partner (PSCP) for all remedial works has been appointed along with independent Cost Advisors and Project Managers who will administer the contract on behalf of GGC. Procurement of Clerk of Works and Supervisor services have commenced. This team will deliver a programme of remedial actions sequenced and phased in response to risk or access constraints over forthcoming years. A decant ward may be needed to provide vacant access for works on a rolling programme

3.4.3 Collaborative dialogue is ongoing with Multiplex to develop and agree a Settlement Agreement incorporating a construction contract to replace the atrium wall linings. Works will comprise the replacement of wall linings on a number of stair and lift towers and to areas on the link bridge. Availability of materials and the necessary phasing to mitigate impact on service activity indicate that once works commence in early 2022 they will take around 12 months to complete.

3.4.4 We continue to meet regularly with statutory authorities and advisors including Fire and Rescue Service, Scottish Government and Glasgow City Council Building Standards to inform and assist with risk management and emerging legislative guidance.

3.5 RHC ward 2A/2B

3.5.1 Ward 2A is an in-patient haemato-oncology unit, also known as Schiehallion, and also houses the National Bone Marrow Transplant Unit and Teenage Cancer Trust. The day care service is in 2B. Significant remedial work to provide HEPA filtered environmental conditions suitable for use by immune-compromised patients including positive pressure single bedrooms and en-suite facilities is nearing completion. Two former patients have visited the new 8-12 year playroom included in the works as a result of their fundraising activities.

3.5.2 Commissioning of all systems is underway. Works were scheduled for completion on 6 October however there have been issues with the resistance testing of the new terminal in-room HEPA filters. The product manufacturer and the Board's Technical Advisors are engaged in product quality assurance. The impact of this is still being determined. NHS remobilisation activities have commenced, with weekly mobilisation meetings ongoing. As soon as rectified the ward will be ready for occupation.

3.6 HSE Update

3.6.1 On the 24 December 2019, the Health and Safety Executive (HSE) served on NHSGGC an Improvement Notice in relation to the ventilation system for Ward 4C. Legal advice was sought and we appealed the Improvement Notice on the grounds that there was no basis in fact for the Improvement Notice to have been served.

3.6.2 Dates have been received by the CLO in respect of the Improvement Notice Appeal with a Preliminary Hearing now scheduled for the 7 March 2022 and an Evidential Hearing is now scheduled for the 21 March 2022 to 15 April 2022. A Case Management Conference will take place towards the end of January 2022.

3.6.3 In respect of the Notice of Contravention, the HSE have confirmed that they were satisfied that the improvements made have resulted in the ventilation system for the above areas being brought in the line with SHTM03-01 as far as is reasonably practicable. The HSE have updated their records accordingly.

3.6.4 The HSE confirmed that, other than the ongoing Appeal against the Improvement Notice, all other aspects detailed in the Notification of Contravention Letter have been addressed. These actions are now closed.

4. Conclusions

4.1 Significant activity continues across all the strands of work related to the QEUH/RHC which is likely to increase further in the coming months. The resource requirements of the senior leadership team and supporting elements, such as the PMO, remain under constant review. The senior team are clear of the priority that is required to ensure we respond effectively to the many requirements.

5. Recommendations

There are no specific recommendations.

6. Implementation

Not applicable at this stage.

7. Evaluation

Not applicable at this stage.

8. Appendices

There are no appendices.

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NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 21 December 2021 at 9.30 am via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Dr Margaret McGuire
Cllr Caroline Bamforth	Ms Ketki Miles
Ms Susan Brimelow	Professor Iain McInnes CBE
Mr Simon Carr	Ms Anne-Marie Monaghan
Cllr Jim Clocherty	Cllr Iain Nicolson
Mr Alan Cowan	Mr Ian Ritchie
Professor Linda de Caestecker	Dr Paul Ryan
Mrs Jane Grant	Mr Frank Shennan
Cllr Mhairi Hunter	Ms Paula Speirs
Mrs Margaret Kerr	Ms Rona Sweeney
Ms Amina Khan	Mr Charles Vincent
Rev John Matthews OBE	Ms Michelle Wailes
Cllr Jonathan McColl	Mr Mark White

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Ann Cameron-Burns	..	Employee Director (Designate)
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Mr James Doherty	..	Senior Communications Officer
Mr William Edwards	..	Director of eHealth
Ms Jennifer Haynes	..	Corporate Services Manager - Governance
Ms Lorna Kelly	..	Interim Director of Primary Care
Ms Christine Laverty	..	Interim Chief Officer, Renfrewshire HSCP
Ms Fiona MacKay	..	Director of Planning
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Julie Murray	..	Chief Officer, East Renfrewshire HSCP
Ms Caroline Sinclair	..	Interim Chief Officer, East Dunbartonshire HSCP
Mr Tom Steele	..	Director of Estates and Facilities
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
111.	**WELCOME AND APOLOGIES**		
	Professor John Brown CBE, Chair, welcomed those present to the December 2021 meeting of the NHS Greater Glasgow and Clyde Board. A particular welcome was offered to Ms Ann Cameron-Burns, who was the new Employee Director for NHSGGC. The meeting combined members joining via video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were reminded to observe appropriate etiquette, and asked to ensure microphones remained on mute until invited to speak, use the virtual hands up function when wishing to contribute, and to refrain from using the chat function. Professor Brown welcomed members of the public who had taken up the invitation to attend the Board meeting, as observers, and therefore the virtual hands up function should not be used by observers, and they must remain on mute throughout the meeting. Professor Brown provided a brief overview of the key items of today's meeting, focusing on the 4 Corporate Aims of Better Health, Better Care, Better Value and Better Workplace, as well as Active Governance. As part of the latter, the governance arrangements would be reviewed as a result of a further surge of COVID-19 cases, ensuring an effective and proportionate response in a time of significant pressure. Professor Brown highlighted that there were three late papers, those being: • Item 14a – Paper 21/86 – Clinical Care and Governance Chair's Report of the meeting held on 14 December 2021 • Item 14b – Paper CCGC(M)21/02 – Clinical Care and Governance approved minute of the meeting held on 14 December 2021 • Item 20 – Paper 21/92 – Staff Governance Annual Report Professor Brown asked Board Members to confirm if they had any objections to accepting the late papers for consideration at today's meeting. Members were content to accept the late papers for consideration. Professor Brown noted that the Board was required to approve the Remobilisation Plan 4 (item 9), rather than to review it for assurance, and that the North East Hub Full Business Case (item 17) was for awareness, not approval.		

			ACTION BY
	Board Member apologies were intimated on behalf of Ms Jacqueline Forbes, Ms Flavia Tudoreanu and Dr Lesley Rousselet. NOTED		

112.	**DECLARATIONS OF INTEREST**		
	Professor Brown invited members to declare any interests in any of the items being discussed. There were no declarations made. In addition, the Chair reminded all members of the requirement to keep their details on the Register of Interests up to date. Members were asked to please inform Ms Jennifer Haynes, and Professor Brown by email, should any of their details change. NOTED		
113.	**MINUTES OF PREVIOUS MEETING HELD 26 OCTOBER 2021**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 26 October 2021 [Paper No. NHSGGC(M)21/07]. On the motion of Mr Ian Ritchie, seconded by Mr John Matthews, the minute of the meeting was approved and accepted as an accurate and complete record. APPROVED		
114.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Board considered the paper 'Rolling Action List' [Paper No. 21/79]. The Board agreed to the closure of 5 actions from the Rolling Action List. APPROVED		
115.	**CHAIR'S REPORT**		

	Professor Brown had attended a number of meetings which had taken place since the last Board meeting, including four Standing Committees meetings (Staff Governance, Acute Services, Finance Planning and Performance, and Audit and Risk). Professor Brown also met with the Standing Committee Chairs Networks, and had regular discussions with the Vice Chairs regarding a wide range of issues. Professor Brown chaired a Board Development Session in November 2021 that focussed on the response to the climate emergency. This session was well attended, and Professor Brown had received positive feedback from the external speakers and Board Members, who were impressed by the work so far in NHSGGC to reduce the carbon footprint, and to develop a more sustainable approach to delivering healthcare. Professor Brown noted his thanks to Mr Tom Steele and his team for their achievements. In addition to attending the December 2021 meeting of the NHS Scotland Chairs with the Cabinet Secretary for Health, Professor Brown and the Chief Executive continued to attend weekly meeting with the Cabinet Secretary, and the NHS Scotland Chairs and Chief Executives. These meetings were mainly focussed on managing a way out of the current situation. Professor Brown also hosted a visit from the Cabinet Secretary to the Contact Tracing Team at Eastbank Centre, where staff shared their experience of working in the COVID-19 Test & Protect system. Professor Brown noted that both he and the Cabinet Secretary were impressed by the people they met, and the professional manner in which they carried out their work. Professor Brown chaired meetings of the Board of the Glasgow Health Sciences Partnership, the NHS Scotland Corporate Governance Steering Group, and the NHS Scotland Global Citizenship Advisory Board. He also attended the 2021 Scottish Health Awards ceremony, and presented the national award for Global Citizenship to Mr Stuart Watson, a plastic surgeon based at Glasgow Royal Infirmary, for his work in Africa. Since the last Board meeting, there had been four meetings with local MSPs and MPs, where Professor Brown, the Chief Executive and the leadership team provided the elected representatives with a detailed update on the response to the pandemic. In addition to these regular meetings with MSPs and MPs, NHSGGC invited the leader of the Scottish Labour Party, Mr Anas Sarwar, to meet with the Chair, Chief Executive and the Board's senior clinical advisors to discuss the concerns that he raised in the parliament concerning the QEUH Campus.		

	Mr Sarwar was invited to hear about the impact of the recent parliamentary debates on staff, and on the relationship between frontline staff and patients. As a practising frontline clinician, Dr Scott Davidson spoke eloquently about this. Professor Brown, the Chief Executive and the team were also keen to engage Mr Sarwar in discussions about how they could work with him to rebuild trust and public confidence in NHSGGC hospitals. Professor Brown noted his disappointment that despite hearing first-hand from clinicians, Mr Sarwar's stance on these matters has not changed. Following the meeting, the Chief Executive wrote to Mr Sarwar, offering to meet with him again to discuss his concerns further, and suggesting that he might like to visit to the QEUH and RHC, where he could meet frontline staff. In the meantime, the leaders of the other opposition parties in the Scottish Parliament have been invited to meet with the Chair and Chief Executive, and receive the same presentation from the senior clinicians. Professor Brown noted his hope that by ensuring they are well informed, properly briefed and fully aware of all the evidence, MSPs will come to the conclusion that the hospitals are safe and the senior leadership of NHSGGC takes infection prevention and control seriously. Once these meetings have been held, Professor Brown will provide Board Members with an update on the situation. <u>NOTED</u>		
116.	**CHIEF EXECUTIVE'S REPORT**		
	Mrs Jane Grant, Chief Executive, provided an overview of activities since the last Board Meeting. She noted that, in addition to the meetings highlighted by the Chair, she had also attended meetings with the Scottish Ambulance Service and Local Authority Chief Executives, as well as other essential meetings, including the Digital Strategic Portfolio Board for NHS Scotland. Mrs Grant also noted the huge amount of work NHSGGC had undertaken in relation to the COP26 conference. Mrs Grant confirmed that she had met with the Scottish Government regarding a number of issues, principally around current challenges and pressures. Mrs Grant also made reference to a Moving Forward Together Programme Board meeting. Mrs Grant confirmed that there continued to be a Gold Command in place for the QEUH work, as well as an equivalent for the COVID-19 pandemic, which continued to meet three times per week. Related to that, Mrs Grant noted the significant amount of activity for the vaccination programme, and that		

	Hampden was opening today as a mass vaccination centre, to increase capacity. Mrs Grant discussed an Advice, Assurance and Review Group, which was a forum for discussion with the Scottish Government, for issues around the Oversight Board, Case Note Review, and external review. Mrs Grant described this as positive and constructive. Mrs Grant confirmed that all recommendations from the Oversight Board had been met, with the exception of 2; the re-opening of Wards 2A/B, and the future management structure of Infection Prevention and Control, including the recruitment of an Associate Director. Both remaining actions should be concluded early in the New Year. Mrs Grant also mentioned the work on Investors in People in Inverclyde, noting that this was a major achievement during challenging times, and there was intent to roll out more widely. Mrs Grant noted that Clydebank Health Centre had opened, which was another major achievement. Two senior appointments had been made since the last Board meeting. Professor Linda de Caestecker, Director of Public Health, will retire in the New Year, and Dr Emilia Crighton will fill the post on an interim basis. Mr Jonathan Best, Chief Operating Officer for Acute Services, will also retire early in the New Year, and Mr William Edwards, the current Director of eHealth, had been appointed into that post. Professor Brown thanked Mrs Grant for the update, and invited comments and questions from members, both on the Chief Executive and Chair's updates. Cllr Jonathan McColl gave positive comments on the opening of the new Clydebank Health Centre. He also made reference to the meeting with Mr Sarwar, stating he felt the Chair, Chief Executive and Senior Team could not have done more to ensure that direct messages went to the right people, and that this had been done in the right way, through clinicians with lived experience. Cllr McColl felt that NHSGGC had demonstrated they were open and welcomed scrutiny. Professor Brown thanks Cllr McColl for his comments, and noted his thanks to Ms Sandra Bustillo, Director of Communications and Public Engagement, who had advised both Professor Brown and Mrs Grant on these matters. <u>NOTED</u>		
117.	**PATIENT STORY**		

	Dr Margaret McGuire, Nurse Director, introduced the Patient Story, which featured a story about a mother (Karin) who donated her kidney to her daughter (Anna), who was born with Bilateral Kidney Dysplasia. Dr McGuire noted that the RHC was one of two transplant centres in the UK who continued with live donations throughout the pandemic. Dr McGuire described that the transplant was scheduled for March 2020, but as this was when the pandemic began, it was rescheduled for August 2020. A huge amount of preparatory work was undertaken in advance of the procedure. In the video, Karin described how supportive the Multi-Disciplinary Team were to the family, in particular the Clinical Nurse Specialists. A lot of psychological preparation work was done with Anna, including producing a book to explain kidney disease to both her, and her friends and brother, to help them understand Anna's condition. The transplant was successful, and whilst there were very positive comments from Karin about the care and treatment, there were also areas for improvement. This included communication in the ward, and Anna having to attend the Emergency Department before being admitted to the ward when she was unwell. Professor Brown thanked Dr McGuire for her presentation, and confirmed the video had been circulated by email to Board Members. Mr Ian Ritchie noted that he was the Chair of the Organ Donation Committee, and felt it was important for the Board to be made aware of the service, and that Anna's story was an example of when the team worked extremely effectively. Mr Ritchie noted that the video was heart-warming, and the team work in a very patient focussed way. Mr Ritchie also noted the coordination effort, and preparation before the procedure, as well as the after care. Although there were some noted requirements for improvement with communication, Mr Ritchie also felt that communication came across strongly as one of the strengths of the team. Ms Susan Brimelow also thanked Dr McGuire for the patient story, noting a personal friend had received a transplant recently, and that it had transformed their quality of life. Ms Brimelow asked how many transplants had been undertaken this year, and Dr McGuire confirmed there had been 11 kidney transplants, 4 of which from living related donors, in the RHC. <u>NOTED</u>		
118.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 21/80] presented by Professor Linda de Caestecker, Director of		

	Public Health. The paper provided an update on the overall position in respect of the NHS Greater Glasgow and Clyde response to managing COVID-19. Professor de Caestecker provided an overview of the current COVID-19 activity. Numbers have continued to increase 863 per 100,000, which was an 87% increase from the previous month. 63% of cases were assumed to be the Omicron variant. Professor de Caestecker noted that rates had increased in all age groups, but particularly in those aged 18-24, where there had been a 3 fold increase. There had, however, also been a doubling in numbers in the 65+ age group in the last week. Hospital cases had also increased, to 154 under 28 days, which was a 20% increase from 7 days before, and double the amount of cases compared to the day before. There had been no outbreaks in clinical teams, but because community rates were increasing, there were increased staff absences, despite exemptions for NHS staff in terms of isolating if the individual was doubly vaccinated and had a negative PCR result. Professor de Caestecker confirmed that as a result of the surge, there was now reduced visiting in acute sites. This same rule had not been applied in Care Homes, and all visitors were asked to do a lateral flow test on the day of their visit. All Care Home residents were fully vaccinated, with boosters, although there had been outbreaks with staff. Care Home cases had been relatively mild, which was a huge change from previous waves. Professor de Caestecker noted that for the vaccination programme, booster doses had been brought forward by 3 months, with the aim that the adult population was boosted by the end of December 2021. This had required a huge amount of work for staff, who had been vaccinating 15,000 people per day, through extended opening hours, and no longer providing the flu vaccination at same time, as the advice was that the booster should be prioritised. There had also been a reduction in the length of time that people had to wait after a vaccination, meaning more space in centres. From today, Hampden had been opened as a mass vaccination centre, which meant an increase in capacity, to vaccinating 24,000+ people per day. Professor de Caestecker noted that media would be taking place later that day to promote the service, which included drop-in appointments in the evening. There had been queuing at centres, which showed the public's desire to receive their booster, and Did Not Attend (DNA) rates were less than 10%. Professor Brown thanked Professor de Caestecker for the update, and invited comments and questions from members.		

Ms Ann Marie Monaghan noted the tremendous about of work, and offered her appreciation. She asked with regards to Care Homes whether there was a contingency plan in place if the situation escalated, which still ensured residents received contact. Professor de Caestecker noted that visiting changed if there was an active outbreak, but that it was still managed so visiting could take place safely, with named visitors, a negative lateral flow result and use of PPE. This was kept under close review at both a local and national level, guidance was updated frequently, and the team kept on top of that.

Dr Paul Ryan asked whether there were particular symptoms of the Omicron variant, and how contact tracing was progressing. Professor de Caestecker noted that the cardinal symptoms remain unchanged, and anyone symptomatic should get a PCR test. There was some reports that Omicron was less likely to impact taste and smell. Professor de Caestecker also noted that contact tracing had been challenging. There was a framework in place that changed dependent on the number of cases. There had also been a move to a greater level of digital contact, by texting contacts. Professor de Caestecker confirmed that now that Omicron was the dominant variant, there was a focused approach, concentrating on high risk settings.

Ms Amina Khan asked how many patients were in ICU. Professor de Caestecker confirmed there were 5 patients in ICU. There was early evidence from South Africa that Omicron was not as severe in its acuity, but as the numbers were so great, the impact was not being underestimated. Ms Khan also asked about staffing pressures, and whether that had been raised with the Scottish Government. Mrs Anne MacPherson noted that the Scottish Government were aware of the situation, and all Health Boards in Scotland were in a similar position. Guidance was well established, having been in place since last year, and so enhanced support for staff, such as R+R hubs, a focus on mental wellbeing, hot meals for staff who were in work overnight, as well as other wellbeing initiatives. Mrs MacPherson also confirmed that NHSGGC continued to to recruit additional staff for the bank and vaccination programme.

Ms Michelle Wailes asked about the vaccination programme, and the impact of a further booster for those who were in a vulnerable group, and had had already received a booster dose that was now 3+ months old. Professor de Caestecker confirmed that those who were severely immuno-suppressed had received a third dose, as well as boosters. Advice on 2nd boosters was awaited, and would partly dependent on further variants. The current booster programme was largely in response to the Omicron variant. Funding for further permanent vaccination staff had been made available.

	Professor Iain McInnes commented on the functioning of immune systems, noting the build-up each vaccine offered, and that additional boosters at the moment may not add value. He also noted that it was reassuring to hear about capacity, as well as asking about community application, antibodies, and the use antivirals at the pre-hospital stage. Professor de Caestecker noted that process would begin in the community today, and Dr Armstrong confirmed that NHSGGC's Director of Pharmacy was leading this approach, which had been issued by the Scottish Government. The process looked at high risks patients, who, following a PCR test, would be given anti-viral medication within 1-4 days. Prof Brown reiterated his thanks to Professor de Caestecker and her team for their hard work and achievements. <u>NOTED</u>		
119.	**REMOBILISATION PLAN 4 AND WINTER PLAN UPDATE**		
	The Board considered the paper 'Remobilisation Plan (RMP) 4 and Winter Plan Update' [Paper No. 21/81] presented by Dr Jennifer Armstrong, Medical Director. Dr Armstrong confirmed that RMP3 was approved in June 2021, and covered up to March 2022. The Scottish Government had asked for RMP4, given the continued uncertainty of the pandemic. There were 4 main components: • A narrative section to describe how the experience of the first 6 months of the year will impact on the remaining 6 months; • A winter plan and self-assessment checklist; • Completed delivery templates describing progress against the key milestones in RMP3; • Revised activity projections for the second half of the year. Dr Armstrong noted that NHSGGC had a strong grip on the work associated with RMP4, with a well-rehearsed process and monitoring of all actions. Work included the major trauma centre, COVID-19 community pathways, a comprehensive COVID-19 vaccination programme, and mental health. Dr Armstrong noted that work had been going well, but there had also been significant caveats because of the recent COVID-19 surge. A letter from Mr John Burns, Chief Operating Officer for NHS Scotland, had been received on 19 November 2021, which confirmed approval of the plan. A further update was due in January 2022, and in July 2022, a three year Operational Recovery Plan was due. Additional plans, as a result of the Omicron surge, had also been developed.		

	RMP4 had been discussed at the Finance, Planning and Performance Committee, and was now coming to the Board for approval. Professor Brown thanked Dr Armstrong, and invited questions from members. Ms Paula Speirs noted that RMP4 had been produced before the recent Omicron surge, and therefore asked whether it was likely that the next quarterly report would show amber rather than green progress. She also asked how risks were being managed. Dr Armstrong confirmed that there would be an impact on service delivery if the surge of Omicron continued, as some services would have to be stepped down and staff redeployed. Dr Armstrong noted that the focus had been on Priority 1 and 2 patients (urgent and cancer patients). The risks were part of the winter planning, with mitigation measures in place. Mr Jonathan Best confirmed that lessons had been learned from first and second waves of the pandemic, and that wherever it was appropriate to continue running services that would happen. For example, endoscopy and imaging will not be stepped down, as these services were very important for cancer diagnoses. Outpatient services would also continue as much as possible, as much of that was now done virtually. These issues were discussed at the three times per week SEG meetings. Professor Brown noted that the plan was designed with the pandemic in mind, but the Omicron surge was a challenge. He noted his thanks to Ms Fiona MacKay and the team. The Board were content to approve RMP4 and the winter plan. <u>APPROVED</u>		
120.	**QEUH/RHC UPDATE**		
	The Board considered the paper 'QEUH/RHC Update' [Paper No. 21/82] presented by Mr Tom Steele, Director of Estates and Facilities. The paper provided an overview of the position regarding the Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC). Mr Steele firstly made reference to the Oversight Board, noting that Mrs Grant had given information in her Chief Executive's update. With regards to the Public Inquiry, Mr Steele confirmed that Lord Brodie had submitted his closing statement, and NHSGGC had subsequently submitted the same. Regular dialogue and full engagement with the Public Inquiry Team continued.		

	In terms of the legal case, the matter of interrupted time bar was heard by Lord Tyre, who found in favour of NHSGGC, rejecting the position that the action was incompetent and should be dismissed. Multiplex had attempted to appeal that decision, which was refused, but may still be possible at a later date. Preparation was underway to go down an adjudication route. NHSGGC continued to work with our legal advisors. Mr Steele noted that for the wider rectification programme, there was an established team in place, considering various aspects of the infrastructure. Communication continued with Multiplex to develop and agree a settlement for the replacement of the atrium wall linings. Should that fail to be achieved, NHSGGC was prepared with an alternative supply chain. For Wards 2a/b, Mr Steele noted that progress was in its final stages before the wards were ready to be re-opened. This included the required validation of the ventilation and domestic water systems. Work continued with the service team, Infection Prevention and Control and external agencies to re-open the wards, which was anticipated to be by the end of January 2022. Mr Steele confirmed that there was no further updated on the HSE appeal, and NHSGGC were expected to provide an update by May 2023. The Board were content to note the significant activity which continued across all of the strands of work related to the QEUH/RHC and Professor Brown thanked Mr Steele and all teams and staff involved in all aspects of the key elements reported. <u>NOTED</u>		
121.	**NHSGGC BOARD PERFORMANCE REPORT**		
	The Board considered the paper 'NHSGGC Board Performance Report' [Paper No. 21/83] presented by the Director of Finance, Mr Mark White. The paper provided an overview of performance. Mr White noted that the report was in a different format, which was more succinct, with greater focus on projections and actions. This format had been present to the Finance, Planning and Performance Committee. Mr White made reference to the 16 key measures, which included focus on activity associated with RMP4. The current position was colour coded using Red, Amber Green status, and Mr White noted the volume of unknowns due to current pandemic situation.		

	Professor Brown thanked Mr White, and invited questions from members. Ms Amina Khan commented on the number of indicators that were red. Mr White noted that the ongoing situation would depend on the impact of the Omicron variant, however, a huge amount of activity continued to be delivered, which was positive for patient care. Mr White acknowledged there was room for improvement. <u>NOTED</u>		
122.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Reporting Template (HAIRT)' [Paper No. 21/84] presented by Professor Angela Wallace, Interim Director for Infection Prevention and Control. The paper provided an overview of the Healthcare Associated Annual Operation Plan (AOP) targets in respect of *Staphylococcus aureus bacteraemia* (SAB), *Clostridioides difficle infections* (CDI), and *E.coli bacteraemias*; incidents and outbreaks and all other healthcare associated infection activities across NHSGGC over the period of September and October 2021 Professor Wallace paid thanks to the Infection Prevention and Control and wider team for their enormous of work, particularly during the further surge in COVID-19 cases. Professor Wallace noted that the 3 AOP targets remained within control limits, and NHSGCG was consistent with the national picture. She also noted the quality improvement work, and that NHSGGC had sustained improvement over time in relation to targets, and staff continued to focus on that. Professor Wallace made reference to the summary position, which showed that Infection Prevention and Control was hardwired into day-to-day business, and was a key feature of recovery and remobilisation. There was regular liaison with Estates and Facilities to ensure safe hospital environments, and continued promotion of the message 'infection control is everyone's business' as part of the Gold Command. Professor Wallace also made reference to the recommendations from the Oversight Board being almost complete, with further improvement taking place, as well as regular testing. Professor Brown thanked Professor Wallace and invited comments and questions from members. Ms Margaret Kerr made reference to a funnel plot diagram on Page 7 of the report, which she took assurance from, and which showed that NHSGGC's intervals are ahead of other Health Boards. Professor		

	Wallace affirmed this was the case, and noted that data was reported to the Scottish Government, who collated it, and it was then shared with Health Boards. The target across NHS Scotland was to reduce avoidable infections, and NHSGGC was within limits. Ms Susan Brimelow noted that in parliament, the First Minister had said that if there were concerns about the QEUH or RHC, that people could contact her. Ms Brimelow therefore asked if NHSGGC had been made aware of any such contact. Mrs Grant and Ms Vanhegan noted that some general queries had come to NHSGGC from the Scottish Government about matters which had been in the media, but there had been no formal notification of infection control related issues. Mr John Matthews commented that he found the level of assurance comforting. He noted that he had found the parliamentary debate ill informed, and there had been a lack of knowledge from MSPs, who did not appear aware of the evidence. Mr Matthews also commented that as Vice Chair of the Board, he was uncomfortable about incorrect information being in the public domain. Professor Brown acknowledged Mr Matthews concerns, and confirmed that these would be recorded. Ms Ann Marie Monaghan noted her comments that the report had offered her assurance and confidence, and also referenced that the report provided evidence that politicians did not seem to be aware of. Ms Monaghan thanked Professor Wallace and her team for work, despite the difficult circumstances. Professor Brown noted the strenuous efforts being made to ensure the evidence was available to politicians, media and the public. Ms Amina Khan noted it may be helpful to do further work in that regard, and Professor Brown confirmed that Ms Sandra Bustillo had been working on that matter. Cllr Jim Clocherty queried why the Health Board remained on special measures, when NHSGGC were reporting assuring data. Professor Brown noted that this was not a decision for the Health Board, and was for the Scottish Government to decide. Mrs Grant confirmed that NHSGGC continued to meet with the Scottish Government, who were content with the progress, efforts and actions. Mrs Grant confirmed that she and the Chief Executive of NHS Scotland would continue discussions in the New Year. In summary, the Board were content to note the HAIRT report; the performance in respect of the Annual Operational Plan (AOP) Standards for SAB, CDI, and ECB; the detailed activity in support of the prevention and control of Healthcare Associated Infections; and the contribution of the infection Prevention and Control Team (IPCT) to the organisation's response to COVID-19. Professor Brown		

	thanked Professor Wallace, the IPCT, and all teams and staff for their contributions to achieving an ongoing, sustained improvement in respect of healthcare associated infections. He noted that the report had provided assurance that NHSGGC hospitals were safe, were continuously improving, quality assessed, and in line or better than the Scotland wide position. NOTED		
123.	**ACUTE SERVICES COMMITTEE UPDATE**		
(a) **(b)**	**CHAIR'S REPORT OF THE MEETING HELD 16 NOVEMBER 2021** The Board were content to note the Chair's Report of the meeting held on 16 November 2021 [Paper No.21/85]. **APPROVED MINUTE OF THE MEETING HELD 21 SEPTEMBER 2021** The Board were content to note the minute of the meeting held on 21 September 2021 [Paper No. ASC(M)21/03]. NOTED		
124.	**CLINICAL & CARE GOVERNANCE COMMITTEE UPDATE**		
(a) **(b)**	**CHAIR'S REPORT OF THE MEETING HELD 14 DECEMBER 2021** The Board were content to note the Chair's Report of the meeting held on 14 December 2021 [Paper No.21/86]. **APPROVED MINUTE OF THE MEETING HELD 14 SEPTEMBER 2021** The Board were content to note the minute of the meeting held on 14 September 2021 [Paper No. CCGC(M)21/02]. NOTED		
125.	**AREA CLINICAL FORUM UPDATE**		
(a) **(b)**	**CHAIR'S REPORT OF THE MEETING HELD 9 DECEMBER 2021** The Board were content to note the Chair's Report of the meeting held on 9 December 2021 [Paper No.21/87]. **APPROVED MINUTE OF THE MEETING HELD 14 SEPTEMBER 2021** The Board were content to note the minute of the meeting held on 14 September 2021 [Paper No. ACF(M)21/05].		

	NOTED		
126.	**NHSGGC FINANCE REPORT**		
	The Board considered the paper 'NHSGGC Finance Report' [Paper No. 21/88] presented by Mr Mark White, Director of Finance, which covered to the end of Month 7. Mr White confirmed there was a £33.1m overspend, which would be managed in the remaining 5 months of the year. COVID-19 spend was £120m, and expected to be £202m by the end of the financial year. This was fully covered by the Scottish Government. In terms of the Financial Improvement Programme, Mr White confirmed there were 232 schemes, delivering £17.6m, with a further £4.04m due for delivery within the year. Mr White also confirmed that the current forecast of core capital resources available to NHSGGC for investment amounted to just under £95.3m Mr White summarised that the prediction remained a breakeven position by the end of the financial year, despite the level of unpredictability due to the continuation of the pandemic. Professor Brown thanked Mr White for the update, and asked about confidence levels for the end of year positions with IJBs. Mr White confirmed there was good confidence. Capital and revenue budgets were discussed, but Mr White said there were no predicted issues at the moment. Ms John Matthews asked about conditionality linked to HSCP monies, but Mr White reassured that this was not a concern. The Board were content to note the NHSGGC Finance Report. NOTED		
127.	**NORTH EAST HUB FULL BUSINESS CASE**		
	The Board considered the paper 'North East Hub Full Business Case' [Paper No. 21/89] presented by Mr Tom Steele, Director of Estates and Facilities. The Board were content to note the report. NOTED		
128.	**FINANCE PLANNING AND PERFORMANCE COMMITTEE UPDATE**		

(a)	**CHAIR'S REPORT OF THE MEETING HELD 7 DECEMBER 2021** The Board were content to note the Chair's Report of the meeting held on 7 December 2021 [Paper No.21/90].		
(b)	**APPROVED MINUTE OF THE MEETING HELD 12 SEPTEMBER 2021** The Board were content to note the minute of the meeting held on 12 September 2021 [Paper No. FPPC(M)21/04]. NOTED		
129.	**AUDIT AND RISK COMMITTEE UPDATE**		
(a)	**CHAIR'S REPORT OF THE MEETING HELD 14 DECEMBER 2021** The Board were content to note the Chair's Report of the meeting held on 14 December 2021 [Paper No.21/91].		
(b)	**APPROVED MINUTE OF THE MEETING HELD 14 SEPTEMBER 2021** The Board were content to note the minute of the meeting held on 14 September 2021 [Paper No. ARC(M)21/03]. NOTED		
130.	**STAFF GOVERNANCE ANNUAL REPORT**		
	The Board considered the paper 'Staff Governance Annual Report' [Paper No. 21/92] presented by Mr Alan Cowan, Co-Chair of the Staff Governance Committee. Mr Cowan noted that the report was for the year 2020/21, and went to the Staff Governance Committee in August 2021. The report covered a wide range of topics, and provided oversight, approval and governance. From an oversight perspective, Mr Cowan noted that there had been particular focus on workforce challenges and the whistleblowing review. Mr Cowan also noted that there had been efforts to improve approval business processes. He made reference to the workforce strategy from Mrs Anne MacPherson and her team, where there had been adequate and effective arrangements in place. Mr Cowan also confirmed that in his capacity as Co-Chair of the Staff Governance Committee, he had written to the First Minister to give a contemporaneous and first-hand account of his view of NHSGGC's staff governance.		

	Professor Brown thanked Mr Cowan, and also all the Committee Chairs, Executive Lead, and Ms Elaine Vanhegan and Mrs Jennifer Haynes and their team, who support the committees. NOTED		
131.	**STAFF GOVERNANCE COMMITTEE UPDATE**		
(a)	**Chair's Report of the Meeting Held 2 November 2021** The Board were content to note the Chair's Report of the meeting held on 2 November 2021 [Paper No.21/94].		
(b)	**Approved minute of the meeting held 3 August 2021** The Board were content to note the minute of the meeting held on 3 August 2021 [Paper No. SGC(M)21/03]. NOTED		
132.	**IMPLEMENTING THE ACTIVE GOVERNANCE APPROACH**		
	The Board considered the paper 'Implementing the Active Governance Approach' [Paper No. 21/95] presented by Ms Elaine Vanhegan, Director of Corporate Services. Ms Vanhegan gave an update on phase 4, and confirmed that despite a challenging year, there was evident progress. Work with Azets was still to be completed, but IJB strategic plans were now going to the Finance Planning and Performance Committee, for greater visibility. This work would conclude in the New Year. Ms Vanhegan also noted that some Committees were still reviewing their reporting, but there was evidence of ongoing work. This would be finalised in later phases. The Scheme of Delegation had been brought back following further comments. Ms Vanhegan noted there had been some discussion prompted by the North East Hub approval process, and there was a proposal to put a cap on limit of approval of non IMT business cases at £20m. This was not in the current Scheme of Delegation, so would change if approved. Ms Vanhegan also noted a change to the membership of committees following Ms Flavia Tudoreanu departure; Ms Michelle Wailes would will join East Renfrewshire IJB, and Ms Paula Speirs would join Glasgow City IJB. Ms Vanhegan also welcomed Ms Ann Cameron-Burns as the new Employee Director.		Ms Vanhegan

	Ms Vanhegan noted that the Acute Services Committee, the Population Health and Wellbeing Committee and the Remuneration Committee had reduced its membership to 7 for the time being. A joint recruitment round was in the planning with NHS Ayrshire and Arran for Ms Tudoreanu's replacement. Ms Vanhegan confirmed that a new model code for members of public bodied had been received on 17 December 2021, and that would be circulated. Professor Brown thanked Ms Vanhegan, and members were asked to note the recommendations around assurance of active governance, approve the Scheme of Delegation with the discussed amendment, note board membership and be aware of the Board's cycle of business. Mr Simon Carr commented that he felt the work was shaping up well, and asked Professor Brown and Ms Vanhegan to consider the timing of Board Development Sessions, in tying them to complicated business in advance. Mr Carr also noted he would find informal sessions useful as a forum of discussion. Professor Brown and Ms Vanhegan committed to taking those points forward. Mrs Margaret Kerr asked about the Scheme of Delegation, referencing a procurement example, and where it should go. Ms Vanhegan committed to clarifying that in the Scheme of Delegation. Ms Kerr also referenced the Board Digital Strategy, which sits under the Audit and Risk Committee, and asked whether that was correct. Professor Brown noted he did not feel strategies should be approved by Committees, but instead they should have a role in the scrutiny of delivery. It was agreed that Professor Brown and Ms Vanhegan would discuss that further. Professor Brown also noted the Board should approve expenditure and business cases for £20m+. Professor Brown then moved on to discuss the current governance structure, and whether there should be a temporary change to support NHSGGC whilst it undertook the significant challenge of a further surge of the COVID-19 pandemic. Professor Brown noted there were three options: 1) Continue with the current Committee structure; 2) Continue with the Committee structure, but paired down, with only items for approval, or items with urgent assurance, or standing business (e.g. the HAIRT report at the Clinical Care and Governance Committee). Meeting durations would be capped at 1.5 hours;		Prof Brown / Ms Vanhegan Ms Vanhegan Prof Brown / Ms Vanhegan

	3) Temporarily stand down all Committees. Mrs Grant noted that she and a number of the Executive Leads felt that Option 2 would be preferable, but that this would need to be flexible given the unpredictability of the situation. Mr John Matthews noted his support for Option 2, as did Ms Paula Speirs, who noted that a further measure could be to minimise papers, and to have verbal updates or presentations whenever possible. She also noted it would be helpful if meetings were cancelled of the Chair and Executive Lead felt there was no pressing business. Ms Amina Khan also supported Option 2. The Board agreed to Option 2, with the added suggestion to minimise papers, and to cancel meetings if there was no pressing business. APPROVED		
133.	**VALEDICTORY**		
	Professor Brown noted that Ms Flavia Tudoreanu was leaving the Board on 31 December 2021, after almost 3 years as a Board Member. During her time, Ms Tudoreanu had made a valued contribution to a number of NHSGGC's Committees, including the Population Health and Wellbeing Committee, the Remuneration Committee and both East Renfrewshire and Glasgow City Integration Joint Boards. Ms Tudoreanu also had an interesting job as the Coordinator of Scottish Campaign for Nuclear Disarmament and as her involvement with the International Campaign to Abolish Nuclear Weapons contributed to their winning the 2017 Nobel Peace Prize. Professor Brown noted that Ms Tudoreanu's unique personal and professional experience has enabled her to bring a new and diverse perspective to the Board. He confirmed that she and her family had decided to return to Romania, where she planned to set up a women's rights charity with the aim of reducing gender inequality, advancing understanding of women's rights and empowering women and girls. Professor Brown wished Ms Tudoreanu well in her future endeavour, and thanked her for her contribution to the Board.		
134.	**DATE AND TIME OF NEXT SCHEDULED MEETING**		
	The next meeting would be held on Tuesday 22 February 2022, at 9.30am, via MS Teams.		

NHS Greater Glasgow & Clyde	**Paper No. 21/82**
Meeting:	**Board Meeting**
Meeting Date:	**21st December 2021**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager	**Tom Steele/Jonathan Best**
Report Author:	**Tom Steele**

1. Introduction

This paper is presented to the Board Meeting to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided to the Committee for the purposes of information and assurance.

2. Background

Committee members will be familiar with the issues in respect of the QEUH and RHC subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of Legal action against Multiplex, Currie & Brown and Capital, the Scottish Hospitals Public Inquiry and the ongoing HSE Appeal. This paper provides an update.

3. Assessment

3.1 Update

Board members will be aware of the significant political debate over recent weeks with the motion, brought by Mr Anas Sarwar MSP, defeated. In parliament the First Minister recorded the significant amount of work that had been undertaken by the Board to address the actions set out in the Government commissioned reviews. Positive dialogue continues with Scottish Government colleagues in terms next steps. Work is underway on a robust communications strategy supporting and reassuring patients, families and staff.

3.2 Oversight Board

Further to publication of the Oversight Board Report and the Case Note Review Report, a comprehensive action plan was developed to ensure all the recommendations, including those of the External Review led by Drs Montgomery and Fraser, were being put in place to address the issues described in the reports. The work of the delivery group (Gold Command), chaired by the Chief Executive, and has overseen progress against the action plan.

The significant progress made was acknowledged by the Advice, Assurance and Review Group (AARG), at the second meeting of this group held on the 19 August. Dialogue continues with the Scottish Government.

Progress as of November 21 is as follows:

- Independent review – 40 of 41 actions complete, 98%
- Oversight Board –21 of 24 actions complete, 88%
- Case Note Review – 43 of 43 actions complete, 100%

The remaining action in the Independent Review and two within the Oversight Board report relates to ongoing discussion with Scottish Government colleagues. The further action remaining within the oversight Board report is in relation to the completion and reopening of Ward 2A & 2B. As noted above discussions with Government colleagues over recent days are supporting this work

3.3 Public Inquiry

The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. The first substantive hearings of the Inquiry commenced on 20th September 2021 and concluded on 14th November. The oral testimony was provided by families and patients affected by the issues being explored by the Terms of Reference of the Inquiry. The Executive Oversight Group continue to review themes across the evidence given. Counsel to the Inquiry provided core participants with his closing statement on 3rd December which was published on the Inquiry website on 9th December. Core participants have until Friday 17th December to conclude their closing statement which, for GGC, will be submitted by our QC further to consultation with the Executive team and the CLO.

The Board continues to co-operate fully with the Inquiry Team. Meetings continue with the dedicated team from the Central Legal Office (CLO) and Inquiry Team Solicitors with documents and narratives being transferred in a coordinated manner. Initial contact has been made regarding the criminal investigation into the deaths of 4 patients which was announced in the media in September.

3.2 The Legal Claim

The legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd, and Capital Property and Infrastructure Ltd was lodged on 22 January 2020. Lord Tyre heard a legal debate on the matter of interrupted time bar and found in favour of NHSGGC, rejecting the position that the action was incompetent and should be dismissed.

The Court has subsequently refused Multiplex and Capita's motion for permission to appeal Lord Tyre's decision. An appeal may still be possible after all the merits of the case have been determined.

The Court decision pauses the action to allow for the claims to be adjudicated. There is continuous exchange and collation of information to prepare for adjudication and to inform potential to engage directly with Multiplex.

3.3 QEUH/RHC Rectification Programme

NHS GGC have appointed a managing contractor and professional advisors to develop and implement a programme of rectification works that are required throughout the Hospitals. A risk based programme of works is being developed in conjunction with our advisory team and site operational estates and facilities staff. Agreement of finalised proposals will require significant engagement with clinical service, IPC teams and other stakeholders to minimise disruption to service delivery.

Dialogue continues with Multiplex to develop and agree a Settlement Agreement for replacement of the atrium wall linings. The NHS GGC appointed team are well advanced with pre-construction activities and will implement the rectification works should the agreement fail to be timeously agreed with Multiplex.

NHSGGC continue to meet regularly with statutory authorities and advisors including Scottish Fire and Rescue Service, Scottish Government and Glasgow City Council Building Standards to inform and assist with risk management and emerging legislative guidance.

3.4 RHC Ward 2A/2B

Progress is being made in the final stages of the works to Wards 2A/B. Alternative replacement HEPA components have arrived on site, this will allow the ventilation systems to be commissioned and balancing to continue. Enhanced water sampling is ongoing with results under scrutiny by the IPC team, NHS Assure and the Board's Authorising Engineer. A clinical move-in date is still to be determined but will be subject to all enhanced water sampling and air tests passing to a standard satisfactory to the IPC team and independent technical advisors.

3.5 HSE Update

In light of the differing processes underway that may impact on the HSE Appeal, the case has been sisted for an 18 month period. GGC are to provide an update by 30 May 2023 with regards to the other legal processes and associated timescales.

4. Conclusions

Significant activity continues across all strands of work relating to QEUH. Clearly the political debates over recent weeks have been particularly challenging, however

moving forward the senior team remain clear on priorities required to ensure effective response to the many demands as well as ensuring patients, families and staff are supported.

5. Recommendations

No specific recommendations

6. Implementation

Describe the next steps required to take any recommendations forward. This should include the resources required, the governance arrangements, the reporting mechanisms, and the communications plan.

7. Evaluation

This is not applicable at this stage

8. Appendices

There are no appendices

NHSGGC (M) 22/01
Minutes 01 – 21

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 22 February 2022 at 9.30 am via Microsoft Teams

PRESENT

Mr Ian Ritchie (in the Chair to Item 09)
Professor John Brown CBE (in the Chair from Item 10)

Dr Jennifer Armstrong	Cllr Jonathan McColl
Cllr Caroline Bamforth	Dr Margaret McGuire
Ms Susan Brimelow	Cllr Sheila Mechan
Ms Ann Cameron-Burns	Ms Ketki Miles
Mr Simon Carr	Professor Iain McInnes CBE
Cllr Jim Clocherty	Ms Anne-Marie Monaghan
Mr Alan Cowan	Cllr Iain Nicolson
Professor Linda de Caestecker	Mr Ian Ritchie
Ms Jacqueline Forbes	Dr Lesley Rousselet
Mr David Gould	Dr Paul Ryan
Mrs Jane Grant	Mr Frank Shennan
Cllr Mhairi Hunter	Ms Rona Sweeney
Mrs Margaret Kerr	Mr Charles Vincent
Ms Amina Khan	Ms Michelle Wailes
Rev John Matthews OBE	Mr Mark White

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Denise Brown	..	Interim Director of eHealth
Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Dr Emilia Crighton	..	Interim Director of Public Health (Designate)
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Ms Sandra Devine		Acting Infection Control Manager
Mr William Edwards	..	Chief Operating Officer (Designate)
Ms Lorna Kelly	..	Interim Director of Primary Care
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Geraldine Mathew	..	Secretariat Manager (Minute)
Ms Julie Murray	..	Chief Officer, East Renfrewshire HSCP
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Angela O'Neill	..	Interim Nurse Director
Ms Catherine Ospedale	..	Deputy Director of Communications
Mr Chris Sanderson	..	Director of Procurement
Mr Tom Steele	..	Director of Estates and Facilities
Mr Allen Stevenson	..	Interim Chief Officer, Inverclyde HSCP
Ms Elaine Vanhegan	..	Director of Corporate Services and Governance
Professor Angela Wallace	..	Interim Executive Director of Infection Prevention and Control

			ACTION BY
01.	**WELCOME AND APOLOGIES**		
	Mr Ian Ritchie, Vice Chair of NHS Greater Glasgow and Clyde (NHSGGC), welcomed those present to the first meeting of NHS Greater Glasgow and Clyde Board of 2022. He explained that, unfortunately Professor John Brown CBE, Chair, had been unavoidably delayed, therefore Mr Ritchie had been asked by Professor Brown to Chair the meeting until Professor Brown was able to join the meeting. Mr Ritchie extended a very warm welcome to Mr David Gould, to his first meeting as a publically appointed Member of the Board. While the Chair noted that this was Mr Gould's first meeting of the NHSGGC Board, it was also the last meeting of Professor Linda de Caestecker, Director of Public Health, Dr Margaret McGuire, Director of Nursing, and Mr Jonathan Best, Chief Operating Officer. As members may be aware, Professor de Caestecker, Dr McGuire and Mr Best, were retiring from the NHS in the next few weeks. As was the Board's tradition, the Chair would reflect on Professor de Caestecker, Dr McGuire and Mr Best's significant contribution to the NHS at the end of today's Board meeting. The meeting combined members joining via video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were reminded to observe appropriate etiquette, and asked to ensure microphones remained on mute until invited to speak, use the virtual hands up function when wishing to contribute, and to refrain from using the chat function. Mr Ritchie welcomed members of the public who had taken up the invitation to attend the Board meeting, as observers, and therefore the virtual hands up function should not be used by observers, and they must remain on mute throughout the meeting. Mr Ritchie provided a brief overview of the key items of today's meeting, focusing on the 4 Corporate Aims of Better Health, Better Care, Better Value and Better Workplace. Mr Ritchie noted that the Board would not be considering the Active Governance Programme at this meeting, given that it had been agreed that these activities would be paused in recognition of the challenges the Executive Leadership Team have faced in responding to the Coronavirus pandemic. However, the Board would consider a paper on the updated responsibilities of Board Members at today's meeting, prompted by the departure of Ms Flavia Tudoreanu and Ms Paula Speirs, and Mr Gould's subsequent appointment to the Board. At that stage of the meeting, the Board would be asked to consider		

			ACTION BY
	whether or not changes were required to the current approach to governance between now and the April 2022 Board Meeting. As discussed at the December 2021 meeting, it was important that governance arrangements remained under review whilst the organisation remained in the grip of the Coronavirus pandemic, to ensure that governance was effective but also proportionate to avoid making unreasonable demands of the Executive Leadership Team particularly during this time when they remain under sustained pressure due to continued challenges presented by the pandemic. Members were asked to keep this in mind when discussing items on today's agenda, particularly the COVID-19 Update, the QEUH/RHC Update, and the Performance Report, as those discussions should inform decisions on what, if any, changes were required to the governance arrangements. The meeting today would be followed by a meeting of the Board of Trustees of the Endowments Fund. Mr Ritchie highlighted that there were three papers that were issued later than the other papers, and asked Members to indicate if there were any objections to the Board considering the three papers: • Item 07 – Paper 22/02 – COVID-19 Update • Item 17a – Paper 22/12 – Chairs Report of Finance, Planning and Performance Committee • Item 19 – Paper 22/14 – Board Member Responsibilities Members were content to accept the late papers for consideration. There were no apologies intimated. **NOTED**		
02.	**DECLARATIONS OF INTEREST**		
	The Chair invited Members to declare any interests in any of the items on today's agenda. There were no declarations made. The Chair reminded Members of the requirement to ensure that their details on the Register of Interests was kept up to date, and asked Members to ensure that any changes were notified to Ms Elaine Vanhegan, Director of Corporate Administration and Governance, and the Board Chair by email. **NOTED**		
03.	**MINUTE OF THE PREVIOUS MEETING HELD 21 DECEMBER 2021**		

			ACTION BY
	The NHSGGC Board considered the minute of the meeting held on Tuesday 21 December 2021, and were content to approve the minute as a complete and accurate record, subject to the following amendments: Item 126, NHSGGC Finance Report, Page 16, 6th Paragraph – Amended to "*Mr* John Matthews". **APPROVED**		
04.	**MATTERS ARISING**		
	BOARD ROLLING ACTION LIST		
	The Board considered the paper 'Rolling Action List' [Paper No. 22/01] and were content to accept the recommendation that two actions were closed. There were no other matters arising. **APPROVED**		
05.	**CHAIRS REPORT**		
	Mr Ian Ritchie provided an overview of activities on behalf of the NHSGGC Board Chair, Professor John Brown CBE. He noted that Professor Brown had attended and contributed to a wide range of meetings since the last Board meeting. These included three Standing Committee meetings, those being the Population Health and Well Being Committee, the Acute Services Committee, and the Finance, Planning and Performance Committee. He also met with the Standing Committee Chairs Network and had regular discussions with the Vice Chairs concerning the challenges facing NHSGGC. In addition to the January meeting of the NHS Scotland Chairs with the Cabinet Secretary, the Chair and Chief Executive have continued to attend the weekly meeting with the Cabinet Secretary and the NHS Scotland Chairs and Chief Executives. They also attended a meeting Chaired by the Deputy First Minister that brought together the leadership of NHS Scotland and the Scottish Local Authorities to consider the challenges facing the integrated health and social care system. All of these meetings have focussed on managing our way out of the current situation, including how we could better support social care and significantly reduce the number of delayed discharges from Acute hospitals.		

			ACTION BY
	Professor Brown and the Chief Executive also met with the Cabinet Secretary and the Director General for Health & Social Care to provide Mr Yousaf and Ms Lamb with a briefing on the progress made to implement the outstanding recommendations from the various reviews and inquiries into the construction of the QEUH campus. It was a very positive meeting and they both expressed their thanks to Ms Jane Grant and everyone involved in tackling the issues that had arisen since the new hospitals opened in 2015. They welcomed the news that the works on Ward 2a/2b were nearing completion. This would result in all the recommendations being completed. The Board Chair was also invited to a meeting of the Scottish Science Advisory Committee where they discussed the future of the laboratories in Scotland, including the NHS regional laboratory at Gartnavel and the Lighthouse laboratory at the QEUH. The focus of the discussion was not only on the need for testing capacity to respond to the pandemic, but also on how we might use these laboratories in future to both support NHS recovery and introduce new tests for a variety of health conditions. Professor Brown chaired a meeting of the NHS Scotland Global Citizenship Advisory Board and chaired an interview panel to recruit a new professional advisor to the Global Citizenship Advisory Board. Since the last Board meeting, there have been two meetings with local MSPs and MPs, where, the Chief Executive and her Leadership Team provided the elected representatives with a detailed update on our response to the pandemic. This was in addition to the weekly update that the Chief Executive provides to the MSPs, MPs and Local Authority Leaders. In future, the face to face meetings would be held every two months, rather than every month. In addition to the regular meetings with MSPs and MPs, the Chief Executive, the Board's senior clinical advisors and Professor Brown met with Mr Alex Cole-Hamilton MSP, leader of the Scottish Liberal Democrats to discuss the concerns raised in the Scottish Parliament concerning the QEUH Campus. The clinicians delivered a presentation that described the work of the QEUH, the clinical outcomes being delivered by the staff who work on the campus and the prevention and management of infections within the healthcare environment. In addition, the impact of the recent parliamentary debates on patients, relatives and staff was discussed, focussing on how we could work together to rebuild trust and public confidence in our hospitals. Mr Cole-Hamilton welcomed this briefing and the efforts our clinicians had put into bringing this information together. This had added to his understanding of the current situation at the QEUH campus and recognised the importance of politicians being fully briefed from all relevant sources.		

			ACTION BY
	Mr Ritchie advised that Professor Brown, the Chief Executive and the Board's senior clinical advisors would shortly meet with Dr Sandesh Gulhane MSP, the Scottish Conservative's Shadow Cabinet Secretary for Health & Social Care on 2 March to share the same presentation with him. It was anticipated that, by ensuring that they were well informed, properly briefed, and fully aware of all the evidence, the leaders of the Scottish Political parties would independently come to the conclusion that the hospitals were safe and the senior leadership of NHSGGC took infection prevention and control extremely seriously. **NOTED**		
06.	**CHIEF EXECUTIVES REPORT**		
	The Chief Executive provided an overview of a range of meetings since the last Board meeting. She noted that COVID-19 remained a significant challenge for a range of teams including Care Homes, Care at Home, Test and Protect, and Acute hospitals. Ms Grant noted that the Gold Command continued to meet twice per week. In addition, other challenges in respect of winter pressures and delayed discharges continued. The National Response Group continued to meet to discuss the ongoing system pressures with other Chairs, Chief Executives, and the Cabinet Secretary. Ms Grant noted a number of other meetings including a meeting with the Director of Finance for NHSGGC, and Audit Scotland; and a meeting of the Regional Cancer Advisory Group. Ms Grant had also visited the new Health and Care Centre located at Clydebank. Ms Grant was impressed by the new Centre and the significant amount of work undertaken by a range of teams and staff to construct the new facility. The Chief Executive reminded Members about the Chairman's Awards which would take place on Wednesday 23 February at 7.00pm. Ms Bustillo agreed to re-circulate the invite to Members. Mr Ritchie thanked Ms Grant for the update and invited comments and questions on the Chief Executives Update and the Chairs Update from members. Rev John Matthews OBE, commented that he had also had the pleasure of visiting the new Centre at Clydebank and noted that he had visited each floor of the facility, and had spoken with a number of staff, all of whom expressed their appreciation of the new facility and the new working environment.		**Ms Bustillo**

			ACTION BY
	In response to a question regarding the laboratory testing facilities, specifically the Lighthouse laboratory, Ms Grant advised that discussions remained ongoing with Scottish Government regarding the facility, and plans were still emerging. A question was raised regarding the challenges associated with delayed discharges, and what actions were being taken to address these. Ms Grant explained that there were ongoing challenges regarding access to Care Homes, and Care at Home, along with difficulties with Adults with Incapacity. She assured Members that extensive work was underway with Health and Social Care Partnerships (HSCPs) and other NHS Boards to address these issues. Dr McGuire added that the reasons for delays were very complex, some of which were out with the control of the Board. **NOTED**		
07.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 `Update' [Paper No. 22/02] presented by the Director of Public Health, Professor Linda de Caestecker. The paper provided an overview of the overall position in respect of the NHSGGC response to managing COVID-19. Prof de Caestecker provided an overview of the key issues. She noted that the number of cases had fallen in recent weeks, however last week had shown an increase in the trajectory. There was an increase in the household transmission rate and this would continue to be monitored very closely. The number of cases recorded per day was currently between 1200 and 1600 cases and improvement was noted in this area due to the uptake of the vaccination programme. Furthermore, the sickness absence rate had fallen, and there had also been a reduction in the number of outbreaks associated with Care Homes. In respect of the Vaccination Programme, Prof de Caestecker noted that there had been a significant amount of activity. 91.3% of the over 18 years old population had received their first dose, 81% had received their second dose, and 89% had received their booster dose. National guidance was awaited in respect of plans for a second booster dose. The Chair thanked Prof de Caestecker for the update and invited comments and questions from members. In response to a question regarding the support in place for clinically vulnerable staff members, Mrs MacPherson, Director of Human Resources and Organisational Development, advised that a cautious approach continued to ensure the safety of the most clinically		

			ACTION BY
	vulnerable staff. Individual risk assessments were in place for this staff group and a number of interventions were in place including significant support for staff suffering from long COVID-19. A blended approach had been taken to working from home arrangements, with phased returns for staff in place, where appropriate. This continued to be a person centred approach and a number of supports were available to staff including psychological services and Cognitive Behavioural Therapy (CBT). A question was raised regarding the position with staff shortages. Mrs MacPherson advised that this remained a challenging position, which continued to be closely monitored by the Staff Governance Committee. She assured members that every avenue was being explored in respect of maximisation of additionality, including the remobilisation of staff to areas under the most pressure, additional administrative support to teams and services, and additional healthcare support workers. Local operational matters were being closely monitored on a daily basis. Continuous recruitment campaigns were underway and an international recruitment campaign had also been launched. Mrs MacPherson noted that the current challenges continued to be experienced by all NHS Boards across Scotland and this was likely to remain a significant challenge over the coming months. In response to a question regarding the Care Homes data and outbreaks, Dr McGuire noted that this had been closely monitored and there were no patterns related to location or provider. More intensive support was provided to Care Homes which were flagged as more likely to experience difficulties, such as those who had recently had a change in senior leadership. A question was raised regarding efforts to improve vaccination rates within the most vulnerable communities. Prof de Caestecker indicated that uptake rates were lowest in the most deprived communities. She assured members that a range of activities were underway to improve access within local communities and also work with Drug and Alcohol Teams, and Homelessness Teams to improve uptake amongst the most vulnerable groups. In response to a question regarding the extent to which positive rates have resulted in clinical risk, Prof de Caestecker confirmed that work had been undertaken with Public Health Scotland colleagues to ascertain this from the routine data available. Whilst it was possible to extract some information, it was not possible to report this on a daily basis, however the results of regular extraction of the data were published via the Public Health Scotland website. A question was raised regarding the proactive retention of staff members. Mrs MacPherson advised that there was a high level		

			ACTION BY
	campaign to focus on the retire/return option available to staff. She highlighted that, due to the impact for medical staff in respect of pensions and lifetime allowance, this remained a national discussion. Furthermore, work continued to implement a range of activities around flexible working and a blended working approach. In summary, the Board were content to note the report and the information provided regarding the current COVID-19 activity within hospitals; the Acute and HSCP updates; Care Homes; Test and Protect and the Vaccination Programme. **NOTED**		
08.	**POPULATION HEALTH AND WELLBEING COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF THE MEETING HELD 19 JANUARY 2022**		
	The Board considered the paper 'Chairs Report of the Meeting held 19 January 2022' [Paper No. 22/03] presented by the Chair of the Population Health and Wellbeing Committee, Rev John Matthews OBE. The Board were content to note the update. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 13 OCTOBER 2021**		
	The Board considered the minute of the Population Health and Wellbeing Committee Meeting of 13 October 2021 [Paper No. PHWBC(M)21/02]. In response to a question regarding the Annual Report on Screening Programmes, if screening programmes had been recommenced, and what work was being undertaken to improve uptake rates in the black and minority ethnic communities (BAME), Prof de Caestecker advised that all of the screening programmes had recommenced, however she noted that there remained some work required to catch up on activity. She noted that uptake remained low within BAME communities, specifically in relation to female screening programmes such as cervical and breast screening, and plans were in place as outlined in the Equalities Health Plan to improve this. Prof de Caestecker agreed to share the Plan with Members for information. A question was raised about the emerging health inequalities exacerbated by the COVID-19 pandemic, and what actions were being taken in respect of this. Prof de Caestecker referred to the		**Prof de Caestecker**

			ACTION BY
	Glasgow Centre for Population Health (GCPH) Report 'Health In a Changing City' which was available on their website. The Report made recommendations that have been discussed in detail at the Population Health and Wellbeing Committee, relating to a number of key factors including benefits, housing, and mental health, along with the population wide impact of the pandemic. There were specific recommendations which could be acted upon in respect of mental health and wellbeing, however many of the recommendations made would require an advocacy approach. The Chair thanked Prof de Caestecker and Rev John Matthews OBE, for the update. The Board were assured by the information provided that work continued via the Population Health and Wellbeing Committee to address the issues raised. **NOTED**		
09.	**NHSGGC BOARD PERFORMANCE REPORT**		
	The Board considered the paper 'NHSGGC Board Performance Report' [Paper No. 22/05] presented by Mr Mark White, Director of Finance. The report provided an overview of performance against the key performance indicators as outlined in the Performance Assurance Framework. Mr White highlighted that the Performance Report was continually evolving. It detailed the current position in respect of the key indicators set as part of the Remobilisation Plan 4 (RMP4) process, and the expected trajectory at year end. There were eight indicators reported as green status, one reported as amber status, and six reported as red status. Mr White noted that the process for submission of the RMP5 was underway, with a target submission date of the end of February 2022, which would include indicators for the new year of 2022/23. There remained key challenges within the Child and Adolescent Mental Health Service (CAMHS), currently at 55%, which was below the target of 70%, and a number of actions were in place to address this. It was anticipated that this target would be met by the end of March 2022. Additionally, challenges were reported in respect of Access to Cancer Services, which was currently at 78.7%, which was below the target of 95%. Overall, performance was assessed as good, however there were specialties which required improvement and significant activities were		

			ACTION BY
	underway to address these challenges and improve performance by the year end. The Chair thanked Mr White for the update and invited comments and questions from members. In response to a question regarding the CAMHS target and activities to reduce the waiting times, Ms Grant assured members that work continued to both address the longest waits, along with managing those patients with the most urgent clinical need. She highlighted that this remained under close scrutiny via regular meetings with Mr White and the Chief Officers of Health and Social Care Partnerships. Following Ms Grant's response, it was agreed that this position would be clearly stated in future Performance Reports. A question was raised about the trend reporting, specifically, that the figures included within the report covered to March 2022, and if further projections were available. Mr White explained that, usually, projections would cover a period of two years, however due to the issues and challenges of target setting during the pandemic, this had been limited to the period of time set by each of the Remobilisation Plans. In response to a question raised about the progress with delayed discharges and whether there was sufficient capacity within the community to move patients from hospital to a more appropriate setting, Ms Susanne Miller, Chief Officer, Glasgow City HSCP, noted that this remained a complex position. Significant investment had been implemented to support assessment and whilst there had been some improvements in some areas, such as Adults with Incapacity (AWI) challenges, there remained greater issues in respect of specialist provision of complex care packages. A further question was raised regarding the number of patients with Learning Disabilities experiencing delayed discharge. Ms Miller confirmed that, again, issues were in relation to access to specialist accommodation rather than issues related to access to assessment. She assured members that this remained under close scrutiny, and that activities were underway as part of the Community Living Fund, to develop additional resources. In summary, the Board were content to note performance across NHSGGC in relation to the KPIs outlined in the Performance Assurance Framework. Mr Ian Ritchie welcomed Professor John Brown CBE to the meeting. Prof Brown resumed his role as Chair.		**Mr White**

10.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Report' [Paper No. 22/06] presented by the Interim Executive Director of Infection Prevention and Control, Prof Angela Wallace. Ms Sandra Devine, Interim Infection Prevention and Control Manager, was also in attendance. The paper provided an overview of Healthcare Associated targets including *Staphylococcus aureus bacteraemias* (SAB), *Clostridioides difficle* infections (CDI), *E.coli* bacteraemias (ECB), incidents and outbreaks and all other healthcare associated infections activities across NHSGGC over November and December 2021. Ms Devine noted that all healthcare associated infections remained within expected confidence intervals, and the position remained stable. She described the actions that had been put in place to drive forward improvements in respect of healthcare associated infections, and noted that real time data was available to all clinical teams via the dashboard, which provided real time information on sources of infections, and allowed prompt action to be taken. COVID-19 continued to impact on frontline teams. All incidents and outbreaks were being reported to ARHAI and a summary of numbers were included in the report. Ms Devine was pleased to note that there were no incidents or outbreaks in November and December 2021 due to any other type of infection. Whilst there had been a slight dip in the compliance with use of the CPE screening tool, she assured members that actions had been taken to address this and ensure that locally, teams were aware of the importance of screening for CPE. The Chair thanked Prof Wallace and Ms Devine for the update and invited comments and questions from members. In response to a question about the E.coli infections, which had shown a slight increase over the period reported, Ms Devine explained that extensive work had been undertaken to review this. She also noted that preventative strategies to reduce ECB were complicated to implement because infections originated from a much wider range of sources however on this occasion 9% of the infections were related to urinary catheters. A number of initiatives have been put in place, e.g. supporting clinical areas to implement the CAUTI bundle and encouraging patients with hydration. The Chair commented that the Healthcare Associated Infection Report was scrutinised at a number of Committees, prior to being presented to the Board. In light of this, the Chair suggested that the Board could be assured that the governance arrangement around		**Ms Vanhegan**

	Infection Prevention Control, including the reporting of infections could be considered as comprehensive and appropriate at this point in time. A question was raised regarding Surgical Site Infection (SSI) surveillance. Ms Devine explained that this had been paused in November and December 2021 because the surveillance nurses were diverted to support the vaccination rollout, however the nurses had returned to their respective posts in February 2022, therefore she assured members that this programme of work was back on track. In response to a question about the number of ward closures and bed days lost, Ms Devine highlighted that this was in relation to the Omicron surge, and the increase in numbers of in-patients as the infection rates increased through the wider population. A comment was raised in respect of the letter by senior clinicians to the Cabinet Secretary regarding infection prevention and control. The letter was very robust and was commended. Additionally, the reply received from the Cabinet Secretary was very supportive and appreciative of the infection prevention and control position within NHSGGC. Prof Wallace added that the letter from senior clinicians very much reflected their experiences of the organisation and of working in the Infection Prevention and Control Team. Prof Wallace added that the letters reflected the passion, commitment and pride with which the clinical teams and Infection Prevention and Control Teams approached their work, and she commended all of the work the teams have done, along with the support and commitment of the Board, Chief Executive, and the Executive Leadership Team. In summary, the Board were content to note the content of the Healthcare Associated Infection Report, the performance in respect of the Annual Operational Plan Standards for SAB, CDI, and ECB, the detailed activity in support of the prevention and control of healthcare associated infections, and the contribution of the IPCT to NHSGGC response to COVID-19. The Board were assured that the organisation had achieved a good level of performance under challenging circumstances, which compared favourably with the rest of Scotland. The Board commended the responsiveness of teams, management grip, and the high level of governance. There was assurance that the hospitals within NHSGGC remained safe, with appropriate infection prevention and control policies and procedures and appropriate governance in place. The Board noted thanks to Prof Wallace, Ms Devine, the Infection Prevention and Control Teams, and all staff for their efforts. The Chair noted Prof Wallace' recent appointment to NHSGGC as Director of Nursing, and would look forward to welcoming Prof Wallace to that role in April 2022. **NOTED**		

11.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC)' [Paper No. 22/04] presented by the Chief Executive, Ms Jane Grant, and Mr Tom Steele, Director of Estates and Facilities. The paper provided an overview of a number of key matters including: • The Oversight Board and Case Note Review Report; • The Public Inquiry; • The Police Investigation; • The Legal Claim; • The Rectification Programme; • Ward 2a/2b. Ms Grant highlighted that a revised structure had been agreed by the Oversight Board. She noted that the Director of Infection Prevention and Control post had been advertised. Work continued in respect of the Public Inquiry, with a large volume of requests for information being responded to. In light of this, increased capacity had been identified for the Programme Management Office, and additional witness support provision, to ensure that all colleagues were supported to give the best contributions they could to the Inquiry. In respect of the Police Scotland investigation, this remained ongoing, and Ms Elaine Vanhegan, Director of Corporate Administration and Governance, had continued to manage this process in conjunction with Police Scotland officials. Progress continued in respect of the civil claims received. Ms Sandra Bustillo, Director of Communications and Engagement, had undertaken significant efforts in respect of ongoing communications about Ward 2a/2b, and Ms Grant commended Ms Bustillo and the Communications and Engagement Team for their efforts to develop a full Communications and Engagement Plan. Mr Steele provided an overview of the position in respect of the Legal Claim, the Rectification Programme, and Ward 2a/2b.		

	The Chair thanked Ms Grant and Mr Steele for the update and invited comments and questions from members. There were no questions or comments raised. In summary, the Board were content to note the significant activity which continued across all of the strands for work related to the QEUH/RHC. The Board were assured that the Leadership Team continued to have a tight grip on all of the strands of work, that there were appropriate resources allocated to support the Legal Claim and the Public Inquiry, that remedial work continued along with adjudication, and that suitable communications plans were in place. The Chair noted thanks on behalf of the Board to everyone involved in each of the strands of work, including Estates and Facilities colleagues, the Infection Prevention and Control Team, the Corporate Administration Team, Mr Steele, Ms Vanhegan and Ms Bustillo. **NOTED**		
12.	**PROCUREMENT STRATEGY**		
	The Board considered the paper 'Procurement Strategy' [Paper No. 22/07] presented by the Director of Estates and Facilities, Mr Tom Steele. The purpose of the paper was to satisfy the Board's legal duty under Section 15 of the Procurement Reform (Scotland) Act to prepare and publish a Procurement Strategy which sets out how regulated procurements (those over £50,000 (ex VAT)) will be carried out. The revised Procurement Strategy covered the period 2022 to 2025 and represented an updated version of the 2019 to 2022 Procurement Strategy. Mr Steele highlighted that the Strategy had been discussed extensively at the recent Finance, Planning and Performance Committee, and noted that the main areas of change within the Strategy. The Chair thanked Mr Steele for the update and invited comments and questions from members. In response to a question about 2.1 – Governance Structure – specifically regarding the statement about the production of a bi-annual report to the Finance, Planning and Performance Committee, Mr Steele clarified that the bi-annual report would be presented to the Corporate Management Team, with an annual report to the Finance, Planning, and Performance Committee. In summary, the Board were content to approve the revised Procurement Strategy for 2022 to 2025. **APPROVED**		

13.	**ACUTE SERVICES COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 18 JANUARY 2022**		
	The Board considered the paper 'Chairs Report of the Acute Services Committee meeting held 18 January 2022' [Paper No. 22/08] presented by Mr Ian Ritchie, Chair of the Acute Services Committee, and were content to note the report. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 16 NOVEMBER 2021**		
	The Board considered the approved minute of the Acute Services Committee meeting of 16 November 2021 [Paper No. ASC(M)21/04] and were content to note this. **NOTED**		
14.	**AREA CLINICAL FORUM UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 10 FEBRUARY 2022**		
	The Board considered the paper 'Chairs Report of the Area Clinical Forum Meeting held 10 February 2022' [Paper No. 22/09] presented by the Chair of the Area Clinical Forum, Dr Lesley Rousselet, and were content to note the report. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 9 DECEMBER 2021**		
	The Board considered the approved minute of the Area Clinical Forum Meeting held 9 December 2021 [Paper No. ACF(M)21/06] and were content to note this. **NOTED**		
15.	**NHSGGC FINANCE REPORT**		
	The Board considered the paper 'NHSGGC Finance Report' [Paper No. 22/10] presented by the Director of Finance, Mr Mark White. The paper provided an overview of the Month 9 financial position, including the position of the Financial Improvement Programme (FIP), the forecast COVID-19 expenditure for 2021/22, and the projected year end position.		

	Mr White summarised that, as at 31 December 2021, the Board's financial ledger highlighted an overspend of £12.6m, attributable to unachieved savings. Direct expenditure on remobilisation and delivery of services due to COVID-19 of £115.6m was reported, and Mr White confirmed that this had been fully funded by Scottish Government. In terms of the Financial Improvement Programme, Mr White noted that, as at 31 December 2021, the Programme achieved £25.5m on a full year basis, against the target of £45m. Whilst this was below the target, Mr White anticipated that this was likely to increase to £30m (under 70% of the target) by the year end. This was a good achievement, given the challenges experienced over the year. In respect of the Capital position, Mr White explained that there remained some spend required to achieve the capital resource limit, and work continued with budget holders to ensure uncommitted balances were addressed, therefore he was confident that this would be achieved by the year end. The underlying deficit had increased significantly, which had been affected by the challenges posed by the COVID-19 pandemic. Mr White assured members that focus on this would continue into 2022/23 to reduce this. The Chair thanked Mr White for the update and invited comments and questions from members. In response to a question regarding a recent meeting with colleagues from Audit Scotland, Mr White assured members that there had been clear visibility of the current position, and discussion with Audit Scotland had focused on routine preparations for the year end, and ensuring that the timetables for financial reporting and audit returned to pre-pandemic schedules. In summary, the Board were content to note the revenue position at month 9; the position with the Financial Improvement Programme; the capital position at month 9 and the projections to the year end. **NOTED**		
16.	**NHSGGC FINANCIAL PLAN 2022/23**		
	The Board considered the paper 'NHSGGC Financial Plan 2022/23' [Paper No. 22/11] presented by the Director of Finance, Mr Mark White. The paper provided an overview of the initial Draft Financial Plan for 2022/23 and outlined the forecast deficit for 2022/23. Mr White highlighted that the Plan had been scrutinised in detail at the recent Finance, Planning and Performance Committee, and was based on current information to date. This remained a fluid picture,		

	given the requirement to receive confirmation from the Scottish Government, and it was likely that this would continue to be into the new financial year, until clarification was received. The total new resources allocated to the organisation was likely to be in the region of £70m, based on an uplift of 2% baseline budget from the Scottish Government and an additional allocation to support the increase in employer National Insurance costs. This was a positive settlement, however there would be challenges to manage increasing costs, along with the Financial Improvement Programme. Mr White expressed concern regarding increase in costs of supplies, increase in energy costs, medical supplies, and the overall impact of inflation. Mr White would continue to report the position to the Finance, Planning and Performance Committee, and the Board, as this developed. The Chair thanked Mr White for the update and invited comments and questions from members. In response to a question regarding the details included on page 6 of the report in relation to repatriation, Mr White clarified that this was a long standing arrangement. Discussions with NHS Lothian colleagues continued in respect of this, and Mr White noted the importance of this service in ensuring the best care for patients. A question was raised regarding the ongoing matters relating to the future of the Test and Protect programme, and if this was likely to create any additional financial pressure. Mr White clarified that he did not anticipate this being an additional financial pressure. Whilst the current situation in respect of COVID-19 funding and consequentials remained unclear, it was not anticipated that this would result in additional pressure, and there were greater concerns in relation to other areas of pressure such as rising energy costs. In summary, the Board were content to note the Draft Financial Plan and the Financial Improvement target for 2022/23, and would anticipate further updates to the Finance, Planning and Performance Committee, and the Board as further details emerged. **NOTED**		
17.	**FINANCE PLANNING AND PERFORMANCE COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 15 FEBRUARY 2022**		
	The Board considered the paper 'Chairs Report of the Finance, Planning and Performance Committee meeting of 15 February 2022' [Paper No. 22/12] presented by the Chair of the Finance, Planning		

	and Performance Committee, Mr Simon Carr. The Board were content to note the report. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 7 DECEMBER 2021**		
	The Board considered the approved minute of the Finance, Planning and Performance Committee meeting of 7 December 2021 [Paper No. FPPC(M)21/05] and were content to note this. **NOTED**		
18.	**STAFF GOVERNANCE COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 1 FEBRUARY 2022**		
	The Board considered the paper 'Chairs Report of the Staff Governance Committee meeting held 1 February 2022' [Paper No.22/13] presented by the Co-Chairs of the Committee, Mr Alan Cowan, and Ms Anne Cameron-Burns. The Board were content to note the report. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 2 NOVEMBER 2021**		
	The Board considered the minute of the Staff Governance Committee meeting held 2 November 2021 [Paper No. SGC(M)21/04] and were content to note this. **NOTED**		
19.	**BOARD MEMBERS RESPONSIBILITIES**		
	The Board considered the paper 'Board Member Responsibilities' [Paper No. 22/14] presented by Ms Elaine Vanhegan, Director of Corporate Administration and Governance. The paper provided an update in respect of the operating requirements for the Board. Ms Vanhegan provided an overview of the changes to member responsibilities, including the recent appointment of Mr Gould as a new Non-Executive Director of the Board, Ms Miles appointment to Glasgow City Integration Joint Board, and Ms Wailes appointment to East Renfrewshire Integration Joint Board. Additionally, Ms Vanhegan noted that the Acute Services Committee, Remuneration Committee, and Population Health and Wellbeing Committee, would continue with one fewer member respectively, until such times as an		

	additional Non-Executive Board Member appointment had been made. Ms Miles would also undertake additional duties and join Ms Khan and Ms Monaghan as a Board Equality and Diversity Champion. Ms Vanhegan further noted that Ms Jennifer Haynes, Corporate Services Manager – Governance, had recently left the organisation, and a recruitment process was underway to appoint to this post which includes the Board Secretary functions. Members were asked to contact Ms Vanhegan and Mrs Mathew regarding any Board Secretary matters in the interim. A further update would be provided to the next Board Meeting in April 2022. The Chair thanked Ms Vanhegan for the update. There were no comments or questions raised. In summary, the Board were content to approve the updated version of Board Members Responsibilities; and approved Ms Miles appointment as Equality and Diversity Champion. **APPROVED**		
20.	**AOCB**		
a)	**GOVERNANCE ARRANGEMENTS**		
	Following discussion and agreement at the NHSGGC Board Meeting held on 21 December 2021, where the Board agreed to invoke the current proportionate governance arrangements to ensure the level of governance was appropriate to the ongoing challenges, Prof Brown proposed that, given the information received today, and the ongoing response to the COVID-19 pandemic, proportionate governance arrangements would continue in the interim, with this being reviewed at the next Board meeting in April 2022. Members were content to approve the proposal and agreed that the current proportionate governance arrangements would continue, and would be reviewed at the next Board meeting in April 2022. **APPROVED**		
b)	**VALEDICTORY**		
	Prof Brown advised the Board of the upcoming retiral of three members of the Executive Team, Prof Linda de Caestecker, Mr Jonathan Best, and Dr Margaret McGuire.		

	Mr Jonathan Best, Chief Operating Officer, joined NHSGGC in 1981 as a Management Trainee. He has held a variety of General Manager roles over the course of his career. In 1999, Mr Best became the Chief Executive of the Yorkhill NHS Trust, having also undertaken roles such as Director of Regional Services, Director of Surgery and Anaesthetics, and Director of the North Sector. Mr Best has excelled in every role he has undertaken, and has always held patients and staff at the centre of everything he has done, and as such, has been widely respected and held in high esteem throughout NHSGGC. He has dedicated his working career in service to the people of Greater Glasgow and Clyde, and has supported colleagues across NHSGGC including the Board Chair and the NHSGGC Board. He has dedicated his personal time to Spina Bifida Scotland as a Non-Executive Director of the Board. Mr Best would be greatly missed by all colleagues he has worked with, and Prof Brown wished Mr Best a very long and happy retirement. Mr Best thanked Prof Brown and the Board. He considered his time in NHSGGC a great privilege, particularly the opportunity to bring about positive changes and put patients and staff first. The last few years have posed unprecedented challenges for the NHS due to the COVID-19 pandemic, and Mr Best was proud of staff and colleagues who had continued with tremendous efforts, passion and pride, despite the significant challenges. He wished Mr Edwards well in his new role as Chief Operating Officer, and gave special thanks to everyone he has had the pleasure of working with. Prof Brown went on to note that Prof Linda de Caestecker joined NHSGGC in 1993, as a Consultant in Public Health Medicine, which, at that time, was led by the Women and Children's Directorate. Following a merge, Prof de Caestecker went on to assume the role of Director of Public Health, and in January 2007 became an Executive Member of the Board. In 2015, Prof de Caestecker undertook a role with FIGO, the International Federation of Gynaecology and Obstetrics, addressing women's health in low resource countries. More recently, during the pandemic, Prof de Caestecker has become a key participant in the UK's response to COVID-19, and has provided specialist expertise and skill. Prof Brown was extremely grateful to Prof de Caestecker for everything she had done for the people of Scotland, and wished her a very long and happy retirement. Prof de Caestecker thanked Prof Brown and the Board. She expressed gratitude for the variety of roles she has had throughout her career. Having worked in Ghana in the 1980's as a Consultant in Gynaecology and Obstetrics, Prof de Caestecker witnessed first-hand the effects of poor conditions on women and children, which led to an interest in public health matters and a desire to address issues such as prevention; access to clean water; housing; and diet. She returned to Scotland and began her training in the Public Health field, and worked on a variety of programmes including screening; the universal parenting programme; introduction of folates supplementation to		

	prevent neutral tube defects. She had worked with a wide range of colleagues, and developed trusted relationships. She was extremely proud of the response of colleagues and staff over the course of the pandemic, who had demonstrated courage, composure, and commitment, and was tremendously proud of the efforts of all of the Public Health Team who had developed a world-class service in areas such as smoking cessation and weight management. Prof de Caestecker thanked all colleagues for the privilege of working with them and wished the Board and colleagues well for the future. Dr Margaret McGuire joined NHSGGC as Director of Nursing in October 2015, following her previous role with NHS Tayside. She began her nursing career in St Vincent's Hospital in Dublin and then moved to Scotland to pursue further training in the field of midwifery. This was an immensely rewarding and challenging role. Dr McGuire then moved into the field of education and exhibited talents in this role. Dr McGuire has been a great professional, an inspirational leader, always exhibits a calm and professional approach, with patients at the heart of all that she has done, and would be extremely missed by all colleagues who have worked with her. Prof Brown wished Dr McGuire a very long and happy retirement. Dr McGuire thanked Prof Brown and the Board. She commented that her career has been an extremely rewarding, challenging and exciting time, and the most important part has been the people she has had the privilege to work with, both the patients and staff. She has learned a significant amount from a number of people she has met over the years and highlighted that teamwork and kindness were the key elements of success. She wished everyone well for the future. **NOTED**		
21.	**DATE OF NEXT MEETING**		
	Tuesday 26 April 2022, at 09:30am, MS Teams.		
	The meeting concluded at 12:35.		

NHS Greater Glasgow and Clyde	**Paper No. 22/04**
Meeting:	**Board Meeting**
Date of Meeting:	**22 February 2022**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Elaine Vanhegan, Director of Corporate Services & Governance**
Report Author:	**Tom Steele, Director of Estates and Facilities** **Elaine Vanhegan, Director of Corporate Services & Governance**

1. Purpose

The purpose of the attached paper is to:

Update the Finance, Planning and Performance Committee on the positon regarding the Queen Elizabeth University Hospital and Royal Hospital for Children in respect of;

- The Oversight Board and Case Note Review Report
- The Public Inquiry
- The Police Investigation
- The Legal Claim.
- The Rectification Programme
- Ward 2a/2b

2. Executive Summary

The paper describes the significant activity which continues across all of the strands of work related to the QEUH/RHC.

3. Recommendations

There are no formal recommendations within the paper.

4. Response Required

This paper is presented for **assurance**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Better Health **Positive**
- Better Care **Positive**
- Better Value **Negative**
- Better Workplace **Positive**
- Equality & Diversity **Neutral**
- Environment **Positive**

6. Engagement and Communication

The issues described within the paper are subject to wide engagement across the organisation with each aspect led by a Corporate Director.

7. Governance Route

The issues described have been considered by the Executive Oversight Group, and the Corporate Management Team, Chaired by the Chief Executive, and the Finance, Planning and Performance Committee.

8. Date Prepared and Issued

Date prepared: 15 February 2022.
Date issued: 15 February 2022.

NHS Greater Glasgow and Clyde	**Paper No. 22/04**
Meeting:	**Board Meeting**
Date of Meeting:	**22 February 2022**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Elaine Vanhegan, Director of Corporate Services & Governance**
Report Author:	**Tom Steele, Director of Estates and Facilities** **Elaine Vanhegan, Director of Corporate Services & Governance**

1. Introduction

This paper is presented to the Finance, Planning and Performance Committee to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided to the Committee for the purposes of information and assurance.

2. Background

The Committee will be familiar with the issues in respect of the QEUH and RHC, subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of legal action against Multiplex, Currie & Brown and Capital, the Scottish Hospitals Public Inquiry and the Police Investigation. The HSE Appeal is currently sisted. This paper provides an update.

3. Assessment

3.1 Oversight Board

A further meeting of the Advice, Assurance and Review Group (AARG) was held in December 2021. A review was undertaken of the outstanding issues from the overarching Action Plan developed to deliver the recommendations from the Oversight Board Report, the Case Note Review Report, and those of the

Independent Review. It was reported that 96% were complete. The remaining action in the Independent Review and two within the Oversight Board report relate to ongoing discussion with Scottish Government colleagues, with regards to the final structure of the IP&C in NHSGGC. The Associate Director of IPC will be recruited to shortly.

The further action remaining within the Oversight Board report is in relation to the completion and reopening of Wards 2A & 2B with an update noted below. It is anticipated that the AARG will meet quarterly, the process of which is being finalised.

3.2 Public Inquiry

The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. The first substantive hearings of the Inquiry commenced on 20 September 2021 and concluded on 14 November 2021. The oral evidence was provided by families and patients affected by the issues being explored by the Terms of Reference of the Inquiry. Closing Statements from both Lord Brodie and Core Participants, including GGC, were published in December 2021. There is no firm date for further hearings for GGC with the next diet scheduled for May and will focus on NHS Lothian, as such NHS GGC does not anticipate any formal hearings until later this calendar year.

A recent meeting was held with the CLO Solicitors and the Inquiry Team Solicitors. The Inquiry Team now plan to issue the Board with specific questions to answer within a given timeframe. The Inquiry Team have agreed to develop a prioritised framework to support the process. The focus on the Requests for Information (RFIs) continues, however the Q&A approach may take precedence moving forward. In terms of RFIs a significant amount of information has already been submitted as noted below:

- Summary of the 54 requests, there are: 24 completed; 15 partially completed; 15 in progress. Of these:

    - Section A numbers 1-6 – 75905 pages circa 8036 documents
    - Section B numbers 7 to 20 - 3500 pages circa 226 documents
    - Section C numbers 21 – 24 - 930 pages circa 336 documents

Action is underway on outstanding requests, some of which require Inquiry Team clarification.

The Board has purchased a Document Management System called Opentext-Accelerate. This is to enable access for robust review of emails, shared drives etc., using key search terms of key current and former employees to respond to the RFIs. In particular the system will help where the request is for all correspondence and will also support a trawl for specific key words e.g. Ventilation which may be of specific interest to the Inquiry.

As the requirements of the Public inquiry evolve, the PMO is being restructured in order to respond. A full time Programme Manager has been appointed to ensure robust project management across the many workstreams (noting also the Covid Public Inquiry will commence imminently). One key work stream is that of Witness

Support and coordination, acknowledging the many different processes underway; e.g. Legal Claim, Police investigation, Inquiry Team requests and CLO/Counsel requests. A working group including, partnership colleagues, is being led by the Director of HR&OD, with the PMO dedicating particular focus.

3.3 Police Investigation

In the middle of December, Police Scotland began approaching staff to commence their investigation, announced in September 2021. In order to ensure staff are supported we have worked with the Senior Investigating Officers and have agreed a single point of contact through which requests for staff access/interview can be made. This is in keeping with the Board's current processes with a Witness Support Officer in place. Staff are advised to contact our Witness Support Officer for advice and support. Guidance for staff is available with the welfare of our staff paramount whilst still engaging with the investigation acknowledging the many other strands underway. Police Scotland have highlighted that the integrity of their processes and investigation is critical.

3.4 Civil Claims

The Board has now received 27 intimations of claim in respect of QEUH and RHC. There is close working between the PMO and CLO on the related themes, however at this stage all cases are currently sisted.

3.5 The Legal Claim

The legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd, and Capital Property and Infrastructure Ltd was lodged on 22nd January 2020. Lord Tyre heard the legal debate on the matter of interrupted time bar and found in favour of NHSGGC, rejecting the defender's position that the action was incompetent and should be dismissed. The Court has subsequently refused Multiplex and Capita's motion for permission to appeal Lord Tyre's decision. There remains a possibility of an appeal at a later stage when all the merits of the case have been determined. The Court decision pauses the action to allow for the claims to be adjudicated and a regular exchange of information continues to prepare for adjudication. Additionally, consideration is being given to engaging directly with Multiplex on a number of the issues. Preparation for court proceedings to be raised in relation to internal cladding issues is complete. Notification to Parent Company will be served this week with court papers lodged 10 days thereafter.

3.6 QEUH/RHC Rectification Programme

Collaborative dialogue continues with Multiplex to develop and agree a Settlement Agreement, including a construction contract to replace the atrium wall linings. Pre-construction activities for replacement of atrium wall linings by an NHSGGC appointed contractor also continue to provide an option, should the conclusion of a settlement agreement with Multiplex fail to be agreed. MacRoberts LLP has issued a letter to Multiplex in relation to the failure of the atrium roof hot wire system requesting that Multiplex remedy the defect in tandem with the cladding works. Multiplex requested additional time to consider the information provided but have

not yet responded. Briefing has commenced with a Board appointed contractor to scope the roof and other rectification workstreams. NHSGGC continue to meet regularly with statutory authorities and advisors, including Scottish Fire and Rescue Service, Scottish Government and Glasgow City Council Building Standards, to inform and assist with risk management and emerging legislative guidance.

3.7 RHC Ward 2A/2B

NHS commissioning activities have concluded on the ventilation and domestic water systems. This has been independently supported by the Board's advisors. Work is ongoing to clinically commission the wards with a view to have them ready for occupation by the start of March. Clinical move in date will be dependent on final ICD sign off of the water sampling which is ongoing with support from independent technical advisors and national agencies.

3.8 Communications

In preparation for the opening of Ward 2A/2B, a comprehensive staff and patient/family communications plan is being delivered, including an orientation video and FAQs. The plan has been developed to incorporate learning from feedback from families on communications and engagement, including recent research carried out on our behalf by the Consultation Institute. The wider QEUH/RHC communications strategy is also making good progress with briefings for key stakeholders, including elected representatives and media, proactive media opportunities to showcase the work of the hospitals and the development of stakeholder written briefing packs.

4. Conclusions

The Executive Oversight Group (EOG) continue to meet weekly to oversee all aspects described in relation to the QEUH and RHC. The Senior Team remain clear that focus is required to ensure effective response to the many demands, as well as ensuring patients, families and staff are supported.

5. Recommendations

No specific recommendations.

6. Implementation

Implementation and ongoing work has been detailed in Section 3.

7. Evaluation

This is not applicable at this stage.

8. Appendices

There are no appendices.

NHSGGC(M) 22/02
Minutes: 22 - 43

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 26 April 2022, at 09:30am via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Rev John Matthews OBE
Cllr Caroline Bamforth	Cllr Sheila Mechan
Ms Susan Brimelow OBE	Ms Ketki Miles
Ms Ann Cameron-Burns	Ms Anne-Marie Monaghan
Mr Simon Carr	Cllr Iain Nicolson
Cllr Jim Clocherty	Mr Ian Ritchie
Dr Emilia Crighton	Dr Lesley Rousselet
Ms Jacqueline Forbes	Dr Paul Ryan
Mr David Gould	Mr Charles Vincent
Mrs Jane Grant	Ms Michelle Wailes
Mrs Margaret Kerr	Professor Angela Wallace
Ms Amina Khan	Mr Mark White

IN ATTENDANCE

Ms Denise Brown	..	Interim Director of eHealth
Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary
Ms Lisa Duthie	..	Senior Auditor, Audit Scotland
Mr William Edwards	..	Chief Operating Officer
Mr Tom Kelly	..	Head of Adult Services: Learning Disability & Recovery
Mrs Geraldine Mathew	..	Secretariat (Minute)
Ms Fiona McEwan	..	Interim Director of Finance
Ms Carron O'Byrne	..	Head of Health & Social Care Services
Ms Angela O'Neill	..	Interim Nurse Director
Ms Nareen Owens	..	Depute Director of Human Resources
Ms Caroline Sinclair	..	Chief Officer, East Dunbartonshire HSCP
Professor Tom Steele	..	Director of Estates and Facilities
Mr Allen Stevenson	..	Interim Chief Officer, Inverclyde HSCP

Ms Elaine Vanhegan	..	Director of Corporate Governance and Administration

			ACTION BY
22.	**WELCOME AND APOLOGIES**		
	Professor John Brown CBE welcomed those present to the April 2022 meeting of NHS Greater Glasgow and Clyde Board. He welcomed Professor Angela Wallace, who had recently taken up post as Nurse Director with NHSGGC. He also welcomed Dr Emilia Crighton, to her first meeting of the Board as Interim Director of Public Health, and welcomed Ms Kim Donald, who had recently taken up post as Corporate Services Manager – Governance/Board Secretary. The meeting combined members joining via video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were reminded to observe appropriate etiquette and asked to ensure microphones remained on mute until invited to speak, use the virtual hands up function when wishing to contribute, and to refrain from using the chat function. The Chair welcomed members of the public who had taken up the invitation to attend the Board meeting, as observers, and therefore the virtual hands up function should not be used by observers, and they must remain on mute throughout the meeting. He noted that the Board would not be considering the Active Governance Programme at this meeting, given the ongoing challenges faced by the Executive Leadership Team. The Board would receive a Progress Report on activities at the June 2022 Board meeting. The agenda item slot would be used to consider and discuss the current governance approach to ensure effective and proportionate governance. As the Chairs Report of the Population Health and Well-Being Committee Meeting of 13 April 2022 [Paper 22/17] was circulated later, the Chair invited members to raise any objections to the consideration of this item. There were no objections made and the Board were content to consider this paper. Apologies were intimated on behalf of Cllr Mhairi Hunter, Professor Iain McInnes, Cllr Jonathan McColl, Mr Alan Cowan, Mr Francis Shennan, and Ms Rona Sweeney.		

			ACTION BY
	NOTED		
22.	**DECLARATIONS OF INTEREST**		
	The Chair invited members to declare any interests in any of the matters being discussed. There were no declarations made. **NOTED**		
23.	**MINUTES OF PREVIOUS MEETING**		
	On the motion of Rev John Matthews OBE, seconded by Dr Paul Ryan, the Board were content to accept the minute of the meeting held on Tuesday 22 February 2022 [Paper No. NHSGGC(M) 22/01] as a complete and accurate record. **APPROVED**		
24.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Board considered the paper 'Rolling Action List' [Paper No. 22/15' and were content to accept the recommendation that three actions were closed from the rolling action list. In addition, the following matters were discussed: Minute No. 08b – Equalities Health Plan Dr Crighton confirmed that the Executive Summary would be circulated to Board members prior to the Board meeting in June 2022. There were no other matters arising noted. **APPROVED**		
25.	**CHAIR'S REPORT**		
	Professor Brown provided an overview of activities undertaken by him since the meeting of the Board in February, including attendance at a number of standing committee meetings, a meeting of the Glasgow Centre for Population Health Board, and meetings with colleagues from Scottish Government on a range of issues including the Queen Elizabeth University Hospital (QEUH). Prof Brown also joined the Chief Executive on the interview panel to appoint to the Director of Finance post.		

			ACTION BY
	Following a successful recruitment process, the successful applicant would be announced in the coming days. Professor Brown also attended the Annual Review with the Chief Executive and the Cabinet Secretary for Health and Social Care, and the Chief Operating Officer for NHS Scotland. Consideration was given to the impact of the QEUH construction issues and the response to the COVID-19 pandemic. In addition, plans to redesign urgent and unscheduled care were discussed, along with NHSGGC's contribution to the organisation of COP26 and the support to the establishment of the NHS Louisa Jordan. The Cabinet Secretary noted his thanks to all staff within NHSGGC for their ongoing commitment and hard work during an extremely challenging period. **NOTED**		
26.	**CHIEF EXECUTIVE'S UPDATE**		
	The Chief Executive provided an overview of a range of meetings she had attended since the last Board meeting, including the Annual Review held on 28 March 2022, meetings with the Cabinet Secretary with regards to the ongoing response to COVID-19, delayed discharge, a meeting of the Advice Assurance and Review Group, a Joint Ministerial Session, and a visit by the Cabinet Secretary to the Royal Alexandra Hospital (RAH). Mrs Grant was pleased to note that, following extensive work by the HR Teams and Management Teams, a cluster of Corporate Teams had achieved Investors in People (IIP) Accreditation. This included Corporate Services, the Estates and Facilities Team, and the eHealth Team. Mrs Grant noted that meetings of the Strategic Executive Group (SEG) had continued, however these had been stepped down to twice per week. A range of external meetings had also taken place including the West of Scotland Regional Group, the Best Start Programme, the Digital Health Programme, and the Test and Protect Steering Group. The Corporate Management Team had also recently attended a Cyber Awareness Session.		

			ACTION BY
	Mrs Grant highlighted some new appointments recently made, those being, the appointment of Ms Christine Laverty, as the Chief Officer of Renfrewshire HSCP, and the appointment of Ms Kate Rocks, as Chief Officer of Inverclyde HSCP. Ms Sandra Devine had also been appointed as the Director for Infection Prevention and Control. The Chair thanked Mrs Grant for the update and invited comments and questions from members. In response to a question about the outcome of the Annual Review, and performance in respect of the Queen Elizabeth University Hospital (QEUH), Professor Brown advised that the discussion with the Cabinet Secretary was in relation to the status of NHSGGC on the NHS Scotland Board Performance Framework and was not related to performance. He advised that a view from Scottish Government colleagues on the status of the organisation in relation to the Performance Management Framework was awaited. In summary, the Board were content to note the Chair's Report and the Chief Executive's Report. **NOTED**		
27.	**PATIENT STORY**		
	Professor Angela Wallace, Nurse Director, introduced a short video presentation, which described the work of the community pharmacy teams in providing support to patients. The Chair thanked everyone who participated in the video presentation, and thanked Tracy, Gillian, and Denise for their input. He noted special thanks to the patients who had participated in the video. **NOTED**		
28.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 22/16] presented by the Interim Director of Public Health, Dr Emilia Crighton, which provided an overview of the overall position in respect of the NHSGGC response to managing COVID-19.		

			ACTION BY
	Dr Crighton explained that the report provided an overview of the ongoing demands associated with COVID-19. She noted that the COVID-19 Executive Group continued to meet regularly. She provided an overview of the current position in Acute Services, and highlighted that, due to a recent surge in cases, this had impacted on the number of patients admitted to hospital, the overall performance, and contributed to ward closures due to COVID-19 infections. Furthermore, there was also a notable increase in those attending Emergency Departments, and an overall increase in demand. Challenges continued in respect of Health and Social Care Partnerships (HSCPs) with delayed discharges, and these were being addressed through daily huddles. In relation to the position in Care Homes, Dr Crighton noted that the number of outbreaks of COVID-19 in Care Homes had reduced. Dr Crighton noted the epidemiology of the Omicron variant and highlighted that work continued to focus on the longer-term transition plans and moving into a different phase. The key elements of this would continue to be the delivery of COVID-19 vaccinations and further guidance was awaited in relation to longer term plans regarding the ongoing booster programme. Dr Crighton recognised the significant impact of COVID-19 on patients and the healthcare system, and she thanked all staff for their ongoing efforts throughout this challenging period. The Chair thanked Dr Crighton for the report and invited comments and questions from members. In response to a question about the position in respect of hospital visiting, Professor Wallace explained that a national restriction on visiting remained in place, except for essential visitors. A Monitoring Group was in place to review the position regularly, and it was anticipated that the position may change in the coming weeks as more restrictions were relaxed. A question was raised about the Lighthouse Laboratory, specifically in relation to the relocation of staff, resources, and equipment. Dr Crighton explained that plans were being developed to ensure that expertise and equipment would be utilised in other areas of the organisation. She noted that this work formed part of the transition plan.		

			ACTION BY
	In response to a question about the reasons which patients were admitted to hospital, and if this was because of COVID-19 infection, or other co-morbidities, Mr William Edwards, Chief Operating Officer, advised that there were a wide range of reasons for admissions. He assured members that focus continued on ensuring effective management of the position, with adherence to infection prevention and control. The number of admissions was reducing, and this was being monitored on a daily basis. A question was raised about the impact of long COVID-19, and Dr Crighton described guidance from NICE which included a definition of long COVID-19. She noted the arrangements in place and the importance of supporting staff with long COVID-19. In response to a question about the challenges of staff absence and the ongoing response to COVID-19, Mrs Grant assured members that regular meetings with Scottish Government colleagues and Chief Operating Officers were in place to continually assess the position. Whilst there had been a reduction in the number of in-patients, the position remained challenging. A question was raised about the decommissioning of the Community Assessment Centres (CACs) and if these sites would return to their original use. Mrs Grant confirmed that these were returning to their original use. There was a further question asked about Barr Street, and Ms Culshaw agreed to check this with colleagues from Glasgow City HSCP. In response to a question about vaccination centre locations and delivery of the vaccination programme, Dr Crighton noted that there were ongoing discussions with Scottish Government colleagues in respect of this. Additionally, the JCVI was considering the guidance for the cohort of patients. Dr Crighton would continue to keep the Board informed as this developed. A question was raised about the integration of treatment for long COVID-19 with existing pathways. Dr Crighton advised that consideration was being given to the respiratory pathway, not just specifically in relation to COVID-19. Dr Armstrong added that, as long COVID-19 was a relatively new condition, there was continually emerging information in relation to this. She noted that the condition affected people in different ways, and four approaches had been developed including, self-management; support from Primary Care; rehabilitation; and secondary care treatment.		Ms Culshaw Dr Crighton

			ACTION BY
	In summary, the Board were content to note the COVID-19 update and the current position in respect of the ongoing challenges in response to COVID-19. **NOTED**		
29.	**POPULATION HEALTH AND WELL BEING COMMITTEE UPDATE**		
a)	**CHAIR'S REPORT OF THE MEETING HELD 13 APRIL 2022**		
	The Board considered the paper 'Chair's Report of the Population Health and Well Being Committee' [Paper No. 22/17] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 19 JANUARY 2022**		
	The Board considered the approved minute of the Population Health and Well Being Committee meeting of 19 January 2022 [Paper No. PHWBC(M)22/01] and were content to note this. **NOTED**		
30.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update' [Paper No. 22/18] presented by the Chief Executive, Mrs Jane Grant. Mrs Grant provided an overview of the current position in respect of the Public Inquiry and noted that significant work continued to support the range of information requests received. Additionally, the Police Scotland Investigation remained ongoing, as well as the Legal Claim. The Chair thanked Mrs Grant for the update and invited comments and questions from members. There were no questions or comments raised. In summary, the Board were content to note the report and were assured by the information provided that work continued in		

			ACTION BY
	respect of the Oversight Board and Case Note Review Report; the Public Inquiry; the Police Scotland Investigation; the Legal Claim; the Rectification Programme; and Ward 2A/2B. **NOTED**		
31.	**TRANSFORMATION OF SPECIALIST NEUROSCIENCES, OMFS AND SPINAL INJURIES SERVICES IN THE WEST OF SCOTLAND – INITIAL AGREEMENT**		
	The Board considered the paper 'Recovery and Renewal - Transformation of Specialist Neurosciences, OMFS, and Spinal Injuries Services in the West of Scotland – Initial Agreement' [Paper No. 22/19] presented by Professor Tom Steele, Director of Estates and Facilities, and Dr Jennifer Armstrong, Medical Director. The Initial Agreement was presented for assurance, following presentation and approval by the Finance, Planning and Performance Committee. Dr Armstrong provided an overview of the range of clinical services within the scope of the transformation. These were a range of specialist services, which were complex in nature. Prof Steele described the challenges from an estate perspective. He noted that, in addition to the compelling clinical case, there were significant issues in respect of the buildings which would be addressed by the redevelopment. The asset management data had been put into the national priority system and this development ranked within the top five. A strategic appraisal had been undertaken and this resulted in five options detailed within the paper. There was a dedicated, in-house team managing the project and further funding had been secured to augment the team. Prof Steele highlighted that optimism bias and risk contingencies had been considered, and benchmarking had been undertaken against a current NHS development in NHS Lanarkshire. The Chair thanked Dr Armstrong and Prof Steele for the report, and invited comments and questions from members. In response to a question about the timescales for the development, and if by augmenting the team, the timescales could be brought forward, Prof Steele explained the process and that additional resource within the team would not change the timescales associated with the project. He highlighted that the timescale for development of the Outline Business Case (OBC)		

			ACTION BY
	was 29 months and noted that the design process would run concurrently with this. Prof Steele also assured members that a wide range of stakeholders had been consulted with, along with colleagues from NHS Assure to ensure that all checks and balances had been undertaken. In summary, the Board were content to note the contents of the Initial Agreement and acknowledged the significance of this investment for the Board; and were assured that the Finance, Planning and Performance Committee had approved the Initial Agreement for submission to the Capital Investment Group. **NOTED**		
32.	**PERFORMANCE REPORT**		
	The Board considered the paper 'Performance Report' [Paper No. 22/20] presented by the Director of Finance, Mr Mark White. The paper provided an overview of performance against the key indicators as outlined in the Performance Assurance Framework. Mr White noted that seven indicators were rated as green, two as amber, and six as red. He noted the current pressures and the impact on some indicators, notably the 62 days cancer target, the delayed discharge target and the TTG target, and improvement of these areas continued to be a key focus. The Chair thanked Mr White for the report, and invited comments and questions from members. In response to a question about forecasted trajectories and availability of live data, as opposed to historical data, Mr White explained that there was a period of validation which resulted in a delay to data being available. A question was raised about the availability of data regarding patients who attended a Minor Injuries Unit (MIU) and were then re-directed to an Emergency Department (ED) and a specific example was described. Mr William Edwards, Chief Operating Officer, assured members that data was recorded where patients presented at MIU but were then re-directed to ED. Ms Sandra Bustillo, Director of Communications and Public Engagement, added that a significant amount of work had been undertaken to ensure members of the public were aware of the role of the MIUs. Mrs Grant added that there was ongoing dialogue with colleagues within NHS 24 and clarification of the pathways would be taken forward. Consideration would be given to the specific example		

			ACTION BY
	given, and further discussion about the pathways and if this was an emerging issue, would take place at the Acute Services Committee. In response to a question about the impact of communications work on service pressures, Ms Bustillo noted that there had been a communications campaign running for some time, on a national level, along with implementation of the Flow Navigation Centre. She highlighted that behaviour change would take some time to influence, and the PEPI Team were undertaking work to research this. A question was raised about the CAMHS service and actions being taken to address the pressures. Mrs Grant assured members that this was managed daily by the HSCP Chief Officers, and a variety of solutions were being developed. In response to a question about the medium-term direction of travel, and how the key actions and interventions would improve performance, Mrs Grant advised that as the organisation approached the end of the financial year, work was required to extend the performance trajectories, along with consideration of the likely future demand. Prof Brown added that, as part of the Active Governance programme, actions were being taken to consider the longer-term planning arrangements with Board and IJBs, along with the Assurance Framework, and this work would be finalised and updated at the Board meeting in June. Further discussion took place about the position in respect of CAMHS performance and the complexities around the challenges. Mrs Grant noted that there were a range of activities being undertaken by the HSCP Chief Officers in respect of these, including consideration of different roles, recruitment, and sustainability, and it was agreed that a short summary would be presented to the Board at the next meeting in June. In summary, the Board were content to note performance across the key performance indicators outlined in the Performance Assurance Framework. **NOTED**		
33.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Report' [Paper No. 22/21] presented by Prof Angela Wallace, Nurse Director. The paper provided an overview of the		

			ACTION BY
	healthcare associated infection report for January and February 2022. Prof Wallace highlighted the positive, stable position across NHSGGC, and the continued focus to maintain and improve performance. She noted the position across all Boards in Scotland, in respect of the Annual Operational Plan (AOP) Standards. The targets remained challenging, and data was currently being finalised. She highlighted the impact of challenges in respect of COVID-19 throughout the months of January and February and noted that the Infection Prevention and Control Team (IPCT) continued with significant effort to ensure safety, and there were no outbreaks reported. There were no unannounced inspections during the reported period, however Prof Wallace noted that an unannounced inspection had taken place in March 2022, the full report of which was expected imminently. The Chair thanked Prof Wallace for the report and invited comments and questions from members. He noted the comprehensive scrutiny of the healthcare associated infection report by the Clinical and Care Governance Committee. There were no questions or comments raised. In summary, the Board were content to note the Healthcare Associated Infection Report; the performance in respect of the AOP Standards for SAB, CDI, and ECB; the detailed activity in support of the prevention and control of healthcare associated infections; and the contribution of the IPCT to NHSGGC response to COVID-19. **NOTED**		
34.	**ACUTE SERVICES COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 22 MARCH 2022**		
	The Board considered the paper 'Chairs Report of the Meeting held 22 March 2022 [Paper No. 22/22] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 18 JANUARY 2022**		

			ACTION BY
	The Board considered the approved minute of the Acute Services Committee meeting of 18 January 2022 [Paper No. ASC(M)22/01] and were content to note this. **NOTED**		
35.	**CLINICAL AND CARE GOVERNANCE COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 1 MARCH 2022**		
	The Board considered the paper 'Chairs Report of Meeting held 1 March 2022' [Paper No. 22/23] and were content to note this. **NOTED**		

b)	**APPROVED MINUTE OF MEETING HELD 14 DECEMBER 2021**		
	The Board considered the approved minute of the Clinical and Care Governance Committee meeting of 14 December 2021 [Paper No. CCGC(M) 21/03] and were content to note this. **NOTED**		
36.	**FINANCE REPORT**		
	The Board considered the paper 'Finance Report' [Paper No. 22/2] presented by Mr Mark White, Director of Finance. The report provided an overview of the Month 11 financial position, including the position of the Financial Improvement Programme and the capital position. Mr White noted that the report had been scrutinised in depth at the recent Finance, Planning and Performance Committee meeting. He noted that focus on the audit process was underway, and it was expected that the organisation would achieve a break-even position, including in respect of the capital resource limit. He noted achievements throughout the year in respect of the Financial Improvement Programme, and that £35m of savings had been achieved. Mr White confirmed that the recurring financial deficit had increased to £120m, due to pressures associated with COVID-19. The Chair thanked Mr White for the report and invite comments and questions from members.		

	In response to a question about IJB reserves, Mr White confirmed that these would be summarised following the year end process once the audit process had been completed. In summary, the Board were content to note the COVID-19 spend; the revenue position at Month 11; the Month 11 position with the Financial Improvement Programme and progress for 2022/23; the capital position at Month 11; and the projected revenue and capital position at 31 March 2022. **NOTED**		Mr White
37.	**FINANCIAL PLAN 2022/23**		
	The Board considered the paper 'Financial Plan 2022/23' [Paper No. 22/25] presented by Mr Mark White, Director of Finance, which provided an overview of the outline forecast deficit for 2022/23, and the draft Financial Improvement Targets for 2022/23. Mr White described the significant financial challenge in NHS Scotland, including the levels of COVID-19 spend and services put in place. The financial challenge for 2022/23 was forecast at £172.7m, and this was based on a 2% uplift of baseline budget. This included £120m of a recurring brought forward deficit from 2021/22. Factoring in recurring savings of £50m and non-recurring funding this was reduced to £81.5m. The Chair thanked Mr White for the report and invited comments and questions from members. In response to a question about timescales and what changes made during the pandemic would continue, Mr White noted that work had begun to consider the additional areas of COVID-19 spend and this would become clearer over time. He expected that an action plan would be developed by summer, and this would likely include some complex areas with forecasts and projections. A question was raised about the cost pressures due to inflation and if the current estimate of 2% would be sufficient. Mr White confirmed that costs in relation to energy cost increases had been considered separately. He noted that 70% of costs were in relation to pay. Additionally, this position would be reviewed as the financial year progressed to re-evaluate this position. In response to a question about the likelihood of suppliers contracted over 3 years wishing to re-negotiate, Mr White		Mr White

	indicated that there may be some who would wish to re-negotiate due to inflation costs, however, this would be monitored moving forward. In summary, the Board were content to note the updated Financial Plan and the Financial Improvement targets for 2022/23. **NOTED**		
38.	**FINANCE, PLANNING AND PERFORMANCE COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 5 APRIL 2022**		
	The Board considered the paper 'Chairs Report of the Meeting held 5 April 2022' [Paper No. 22/26] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 15 FEBRUARY 2022**		
	The Board considered the approved minute of the Finance, Planning and Performance Committee meeting of 15 February 2022 [Paper No. FPPC(M)22/01] and were content to note this. **NOTED**		
39.	**AUDIT AND RISK COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 15 MARCH 2022**		
	The Board considered the paper 'Chairs Report of the meeting held 15 March 2022' [Paper No. 22/27] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 14 DECEMBER 2021**		
	The Board considered the approved minute of the Audit and Risk Committee meeting of 14 December 2021 [Paper No. ARC(M)21/04] and were content to note this. **NOTED**		

40.	**RESEARCH AND INNOVATION ANNUAL REPORT**		
	The Board considered the paper 'Department of Research and Innovation: Board Report 2021 – Recovery, Resilience and Growth' [Paper No. 22/28] presented by Dr Jennifer Armstrong, Medical Director, and Prof Julie Brittenden, Director of Research and Development. The paper described the breadth and diversity of innovative research undertaken within NHSGGC, enabled through successful collaboration with academia and industry. Prof Brittenden provided a presentation which detailed a number of key areas including recruitment to clinical research studies; the recommencement of over 1100 studies paused during COVID-19, and an additional 300 new studies commenced; leading role in the participation and delivery of 4 vaccine trials; innovation projects and ongoing collaboration with industry and academic partners; promotion of patient and public engagement; the financial income generated through research which was useful for capacity building and the facilitation of further research and innovation; and building future research and innovation workforce capacity. The Chair thanked Dr Armstrong and Prof Brittenden for the report and presentation, and invited comments and questions from members. In response to a question about the impact of Brexit upon research and innovation projects, Prof Brittenden noted that there was swift mobilisation of the team to ensure minimal impact, however as with most areas of industry there have been opportunities and risks associated with Brexit. A question was raised about the costs associated with research and innovation. Prof Brittenden noted that funding for research was allocated by the Scottish Government, along with some innovation funding. All costs were agreed at a national level. In response to a question about the number of projects which do not become adopted as clinical practice, Prof Brittenden noted that many of the studies which had a negative outcome were still very useful, for example, COVID-19 trials, and protects patients from being exposed to treatments that were not beneficial. In summary, the Board were content to note the research and innovation activity, exemplars, and opportunities. **NOTED**		

41.	**GOVERNANCE UPDATE**		
	The Board agreed to consider this matter as a verbal item. Prof Brown noted the ongoing proportionate governance approach taken during the COVID-19 pandemic. He noted that, to date, the Board had been focused on the short-term requirements, however he was keen that, moving forward, more consideration was given to the medium and long-term focus. He was pleased to note that significant work had been done to develop more manageable reports and papers presented, more verbal updates and presentations. He suggested that, moving forward, consideration be given to circulation of presentation slides in advance of Board and Committee meetings. Prof Brown wished to consider the options available to move to a hybrid model for meetings, whilst ensuring safety of members and mitigation of risks. The format of using MS Teams to conduct Board meetings over the course of the pandemic has allowed the meeting to become more accessible to members of the public to observe, and Prof Brown was keen to maintain this. Therefore, he asked that consideration be given to exploring locations available to host Board meetings in a hybrid format to allow some members, and members of the public to join via MS Teams. It was noted that members were keen to receive more presentations from clinical services at Committee meetings, to discuss areas of success and areas of difficulty. Prof Brown commented that recommencement of the Board visiting programme may contribute to this and asked that Committee Chairs discuss with the Executive Lead of the Committee which relevant areas they would like to focus time on, after which Ms Vanhegan would develop a Board visiting programme for 2022/23. Whilst the Board were keen to begin to develop a visiting programme, it was acknowledged that consideration would be given to ensuring a balance, given the ongoing pressures within services. In response to a question about the current Board Member Responsibilities document, Ms Vanhegan noted that this document was updated on an ongoing basis and agreed to circulate the most up to date version to members. In summary, the Board were content to note the current position in respect of governance and agreed that actions would be taken to move to a hybrid model of meetings, with consideration of suitable locations to hold Board meetings. In addition, the Board		Secretary Secretary Ms Vanhegan/ Secretary Secretary

	noted that a Board visiting programme would be developed in due course, with sensitivity given to services and departments which remained under pressure. **NOTED**		
42.	**VALEDICTORY**		
	Prof Brown noted that this would be Mrs Geraldine Mathew's last Board meeting as Secretariat Manager, as she had recently been appointed to the role of Board Secretary within NHS 24. Prof Brown wished to note thanks on behalf of the Board to Mrs Mathew for her support and work over the past 4 years. Prof Brown noted that Mr Mark White, Director of Finance, would shorty be leaving the organisation for a new role. Mr White was an esteemed Director of Finance, who had successfully led the Board and the organisation through unprecedented challenges, whilst delivering a balanced budget. In his time in post, Mr White had developed a successful Finance and Performance Team, and his ability to engage with the Board, Executive Team, Senior Management, and all staff has been exceptional. Prof Brown wished Mr White well for the future and noted that he would be missed by many colleagues. **NOTED**		
43.	**DATE AND TIME OF NEXT SCHEDULED MEETING**		
	The next meeting would be held on Tuesday 28 June 2022, at 9.30 am.		
	The meeting concluded at 12.35pm		

NHS Greater Glasgow and Clyde	**Paper No. 22/18**
Meeting:	**NHS Board Meeting**
Date of Meeting:	**26 April 2022**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Tom Steele, Director of Estates and Facilities Elaine Vanhegan, Director of Corporate Services & Governance**
Report Author:	**Tom Steele, Director of Estates and Facilities Elaine Vanhegan, Director of Corporate Services & Governance**

1. Purpose

The purpose of the attached paper is to:

Update the NHS Board on the positon regarding the Queen Elizabeth University Hospital and Royal Hospital for Children in respect of;

- The Oversight Board and Case Note Review Report
- The Public Inquiry
- The Police Investigation
- The Legal Claim
- The Rectification Programme
- Ward 2A/2B

2. Executive Summary

The paper describes the significant activity which continues across all of the strands of work related to the QEUH/RHC.

3. Recommendations

There are no formal recommendations within the paper.

4. Response Required

This paper is presented for **awareness**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Better Health **Positive**
- Better Care **Positive**
- Better Value **Negative**
- Better Workplace **Positive**
- Equality & Diversity **Neutral**
- Environment **Positive**

6. Engagement and Communication

The issues described within the paper are subject to wide engagement across the organisation with each aspect led by a Corporate Director.

7. Governance Route

The issues described have been considered by the Executive Oversight Group, Chaired by the Chief Executive.

8. Date Prepared and Issued

Date prepared: 19 April 2022
Date issued: 19 April 2022

NHS Greater Glasgow and Clyde	**Paper No. 22/18**
Meeting:	**NHS Board**
Date of Meeting:	**26 April 2022**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Tom Steele, Director of Estates and Facilities Elaine Vanhegan, Director of Corporate Services & Governance**
Report Author:	**Tom Steele, Director of Estates and Facilities Elaine Vanhegan, Director of Corporate Services & Governance**

1. Introduction

This paper is presented to the NHS Board to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided to Board for the purposes of information and assurance.

2. Background

The Board will be familiar with the issues in respect of the QEUH and RHC, subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of legal action against Multiplex, Currie & Brown and Capita, the Scottish Hospitals Public Inquiry and the Police Investigation. The HSE Appeal is currently sisted. This paper provides an update.

3. Assessment

3.1 Oversight Board

All actions in response to the 108 recommendations from the Oversight Board Report, the Case Note Review Report and the External Review Report have been completed, with a comprehensive audit process in place. Dialogue continues with the Scottish Government regarding next steps in terms of any de-escalation.

3.2 Public Inquiry

The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. The first substantive hearings of the Inquiry commenced on 20 September 2021 and concluded on 14 November 2021. The oral evidence was provided by families and patients affected by the issues being explored by the Terms of Reference of the Inquiry. The next diet of hearings are scheduled for May and October 2022, both of which will focus on NHS Lothian. It is worthy of note that the first week in the May hearings will consider the Theory and Practice of Ventilation which will be of particular interest to the Board.

Dates have now been fixed for the next diet of oral hearings relating to the QEUH and RHC which have been scheduled to take place from 31 October until 9 December 2022. It is then anticipated that further hearings will be set into 2023 and potentially into 2024. The scope of the hearings have yet to be finalised.

The Witness Engagement and Support Team (WEST) of the Inquiry have begun to make contact with key individuals within NHSGGC, with our Witness Support process also engaged in this element of the work focussing on the welfare of our staff.

The Inquiry's approach to requesting information (RFIs) has moved from only requesting documentation e.g. minutes and papers to a Q&A approach. Five tranches have been received to date, all of which involve significant work and review. Through the CLO dialogue continues with the Inquiry Team regarding timescales and detail. The Executive Oversight Group, which continues to meet weekly, is overseeing all submissions.

3.3 Police Investigation

Police Scotland continue their investigation in respect of four deaths at the QEUH/RHC. We continue to work in a collaborative manner with the Senior Investigating Officers in order to ensure staff are supported; with a single point of contact through which requests for staff access/interview and information can be made. This is in keeping with the Board's current processes with a Witness Support Officer in place. Staff are advised to contact our Witness Support Officer for advice and support. Guidance for staff is available as the welfare of our staff remains paramount while we engage with the investigation, acknowledging the many other strands that are underway.

3.4 Civil Claims

The Board has now received 28 intimations of claim in respect of the QEUH and RHC. There is close working between the PMO and CLO on the related themes, however, at this stage all cases are currently sisted.

3.5 The Legal Claim

The legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd, and Capital Property and Infrastructure Ltd was lodged on 22nd January 2020. Lord Tyre heard the legal debate on the matter of interrupted time bar and found in favour of NHSGGC, rejecting the defender's position that the action was incompetent and should be dismissed. The Court has subsequently refused Multiplex and Capital's motion for permission to appeal Lord Tyre's decision. There remains a possibility of an appeal at a later stage when all the merits of the case have been determined. The Court decision pauses the action to allow for the claims to be adjudicated, and a regular exchange of information continues to prepare for adjudication. Additionally, consideration is being given to engaging directly with Multiplex on a number of the issues. Two further court summons were served to Multiplex and their Parent Company in relation to the chilled water system in April 2021, and in relation to internal cladding issues in March 2022**.**

3.6 QEUH/RHC Rectification Programme

Despite competitive dialogue, Multiplex have advised that they will no longer engage further in the 'without prejudice' discussions regarding remedial works to the Adult Atrium Cladding at the QEUH. This scenario was a known risk and the mitigating position of a contractor directly appointed by NHSGGC is in place with progress on pre-construction activities well advanced. Multiplex have not yet formally withdrawn from the request that they will remedy the defect in relation to the failure of the atrium roof hot wire system. Briefing and pre-construction design activities have commenced with a Board appointed contractor on various rectification work-streams including: ETFE roof, improvements to energy centre performance, glazing remediation and the feasibility of further ventilation improvements. NHSGGC continues to meet regularly with statutory authorities and advisors, including Scottish Fire and Rescue Service, Scottish Government and Glasgow City Council Building Standards, to inform and assist with risk management and emerging legislative guidance.

3.7 RHC Ward 2A/2B

The successful commissioning of the newly refurbished Schiehallion Unit, previously known as wards 2A and 2B, was the culmination of significant complex planning and partnership working. External agencies and expert advisors were involved throughout the commissioning process including NHS Assure, Authorising Engineers and the Scottish Government, in assuring the safety of all services including water and ventilation.

The Schiehallion Unit reopened on Wednesday 9th March 2022. The smooth transfer process was the culmination of multidisciplinary team working and planning across an extensive range of service units and the clinical team. Feedback has been extremely positive from both staff and patients since the move.

The MIBG facility within the ward is now ready for use, with the first patient scheduled for early April 2022. This new national service was described by one consultant as a 'game-changer' for Scottish cancer care. This facility is a specialised radiotherapy

service giving care to children who, up until now, have had to travel to London for the treatment. This unit will also treat children from the North of England.

4. Conclusions

The Executive Oversight Group (EOG) continue to meet weekly to oversee all aspects described in relation to the QEUH and RHC. The Senior Team remain clear that focus is required to ensure effective response to the many demands, as well as ensuring patients, families and staff are supported.

5. Recommendations

No specific recommendations.

6. Implementation

Implementation and ongoing work has been detailed in Section 3.

7. Evaluation

This is not applicable at this stage.

8. Appendices

There are no appendices.

NHSGGC(M) 22/03
Minutes: 44 - 73

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
NHS Greater Glasgow and Clyde Board
held on Tuesday 28 June 2022 at 10.30am
via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Cllr Martin McCluskey
Ms Susan Brimelow OBE	Cllr Collette McDiarmid
Cllr Jacqueline Cameron	Cllr Michelle McGinty
Ms Ann Cameron-Burns	Professor Iain McInnes
Mr Simon Carr	Ms Ketki Miles
Mr Alan Cowan	Ms Anne-Marie Monaghan
Dr Emilia Crighton	Mr Colin Neil
Cllr Chris Cunningham	Dr Paul Ryan
Mr David Gould	Mr Frank Shennan
Mrs Jane Grant	Mr Charles Vincent
Mrs Margaret Kerr	Ms Michelle Wailes
Ms Amina Khan	Professor Angela Wallace
Rev John Matthews OBE	

IN ATTENDANCE

Ms Denise Brown	..	Interim Director of eHealth
Ms Sandra Bustillo	..	Director of Communications and Public Engagement
Ms Jackie Carrigan	..	Assistant Director of Finance
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Ms Kim Donald	..	Corporate Services Manager – Governance/Board Secretary (Minute)
Ms Lisa Duthie	..	Senior Auditor, Audit Scotland
Mr William Edwards	..	Chief Operating Officer
Ms Dianne Foy	..	Non-Executive Board Member - Observing
Ms Susan Manion	..	Chief Officer, GP OOH
Ms Fiona McEwan	..	Interim Director of Finance
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Catherine Ospedale	..	Deputy Director of Communications
Mr Iain Paterson	..	Corporate Services Manager - Compliance
Professor Tom Steele	..	Director of Estates and Facilities
Ms Elaine Vanhegan	..	Director of Corporate Governance and Administration

			ACTION BY
44.	**WELCOME AND APOLOGIES**		
	Professor John Brown CBE welcomed those present to the June 2022 meeting of NHS Greater Glasgow and Clyde Board, noting the following newly appointed Board Members: • Ms Dianne Foy (publicly appointed member). • Councillor Jacqueline Cameron (Nominated by Renfrewshire Council) • Councillor Chris Cunningham (Nominated by Glasgow City Council) • Councillor Martin McCluskey (Nominated by Inverclyde Council) • Councillor Collette MacDiarmid (Nominated by East Dunbartonshire Council) and • Councillor Michelle McGinty (Nominated by West Dunbartonshire Council) The Chair noted that the stakeholder member from East Renfrewshire Council has not been appointed yet, but he would expect them to be in place for the August Board Meeting. The Chair confirmed that this would be Audit Scotland's last meeting as the Board's external auditors and thanked Mr John Cornett and Ms Liz Maconachie for their expert advice and support to date. The Board's new external auditors were Ernst & Young. The meeting combined members joining via video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were reminded to observe appropriate etiquette and asked to ensure microphones remained on mute until invited to speak, use the virtual hands up function when wishing to contribute, and to refrain from using the chat function. The Chair welcomed members of the public who had taken up the invitation to attend the Board meeting, as observers, and therefore the virtual hands up function should not be used by observers, and they must remain on mute throughout the meeting. The Chair acknowledged length of the agenda and explained that the one of the purposes of the meeting was to formally review and approve the Annual Accounts. The Chair also highlighted the importance of the agenda's focus on the progress being made towards achieving our four Corporate Aims of:		

			ACTION BY
	• Better Health – that is improving the health & wellbeing of the population • Better Care – improving the individual experience of healthcare • Better Value - through reducing the cost of delivering healthcare, and • Better Workplace – creating a great place to work. As the following items were circulated to Members late, the Chair invited members to raise any objections to the consideration of this items: • Item 7 – Annual Report for the Board of NHSGGC and the Auditor General for Scotland 2021/22 • Item 8 – NHSGGC Annual Reports and Consolidated Accounts 2021/22 • Item 9 – Governance Statement 2021/22 • Item 16(a) – Acute Services Committee Update • Item 19 – NHSGGC Finance Report • Item 25 – Implementing Active Governance Approach Update • Item 27 – Review of Governance Committee and Integration Joint Board Membership There were no objections made and the Board were content to consider these items. Apologies were intimated on behalf of Ms Rona Sweeney, Dr Lesley Rousselet and Ms Julie Murray. **NOTED**		
45.	**DECLARATIONS OF INTEREST**		
	The Chair invited members to declare any interests in any of the matters being discussed. There were no declarations made. **NOTED**		
46.	**MINUTES OF PREVIOUS MEETING**		
	On the motion of Rev John Matthews OBE, seconded by Ms Susan Brimelow OBE, the Board were content to accept the minute of the meeting held on Tuesday 26 April 2022 [Paper No. NHSGGC(M) 22/02] as a complete and accurate record. **APPROVED**		

			ACTION BY
47.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Board considered the paper 'Rolling Action List' [Paper No. 22/30' and were content to accept the recommendation that 10 actions were closed from the rolling action list. There were no other matters arising noted. **APPROVED**		
48.	**CHAIR'S REPORT**		
	Professor Brown provided an overview of activities undertaken by him since the meeting of the Board in April 2022. These included the attendance at a number of standing committee meetings, where the challenges facing NHS Greater Glasgow and Clyde had been discussed. These discussions included consideration by the Standing Committee Chairs Network of our governance arrangements going forward, specifically the move towards hybrid meetings. Prof Brown also joined the Chief Executive in regular meetings with the Cabinet Secretary and Scottish Government officials to discuss the Board's response to system pressures. The May Board Seminar considered, in detail, the Boards approach to equality, diversity and inclusion. Prof Brown was pleased to note that he has had very positive feedback from the event and acknowledged that we had taken another step in the right direction, with work continuing to ensure that the organisational culture embraces equality, diversity and inclusion. Prof Brown had met with Mr Ian Gray MSP (the Scottish Government Minister for Culture, Europe and International Development) to discuss the NHS Scotland approach to global citizenship. Additionally, Prof Brown chaired the Global Citizenship Advisory Board meeting. He was pleased to report that that there had been good progress in developing our approach to global citizenship across the health boards and noted that this work would be shared at a future development session. Prof Brown was keen to explore supporting the health and wellbeing of the student population and had met with Lady Rae, the Rector of the University of Glasgow, to discuss a joint		

			ACTION BY
	approach to this work. This was also being explored further by the executive leadership team. Alongside these meetings, Prof Brown was recruiting Board Members for NHS Ayrshire and Arran and for our own Board. Prof Brown was keen to note that the quality of the applications was very high and we were able to recommend successful candidates for both Boards to the Cabinet Secretary. The NHSGGC successful candidate was Dianne Foy. Prof Brown reported that he had completed the second edition of the Blueprint for Good Governance in NHS Scotland and expected publication by the Scottish Government in the next few weeks. Prof Brown officially opened the new museum at the Glasgow Royal Infirmary and encouraged members to visit. In addition to the meetings noted above, Prof Brown attended the QEUH to present awards at the South Sector's Quality Improvement event. This included the annual Dame Denise Coia Award for Quality Improvement in Patient Care. Prof Brown highlighted that he was very impressed by the improvement projects that had been entered, and the progress in embedding a clinically-led continuous improvement culture was evident. Prof Brown was pleased to advise Members that NHS Greater Glasgow and Clyde had been de-escalated from level 4 to level 2 of the NHS Scotland Performance Management Framework. Prof Brown thanked Caroline Lamb, the Director General and Chief Executive of NHS Scotland, on behalf of the Board. Prof Brown stressed the importance of the public knowing that the Scottish Government have confidence in the Board and the systems and processes in place to mitigate and manage the risks associated with healthcare acquired infections on the Queen Elizabeth site. Along with this is the recognition of our hard working and committed staff ensuring that the highest quality of care is offered to our patients. Prof Brown also acknowledged all colleagues who had contributed to responding to the review findings regarding infection prevention and control and that their hard work has also been recognised by the Scottish Government. **NOTED**		

			ACTION BY
49.	**CHIEF EXECUTIVE'S UPDATE**		
	The Chief Executive provided an overview of a range of meetings she had attended since the last Board meeting, and highlighted the ongoing challenges faced by the board in light of the increasing COVID numbers. Mrs Grant was pleased to report that the Health Board had been de-escalated from Level 4 to Level 2. She noted that there had been two unannounced Health Improvement Scotland (HIS) visits and, although we have not had the published report, the initial feedback had been positive. Mr John Burns, Chief Operating Officer for NHS Scotland, visited the Health Board and met with the Corporate Management Team to discuss the challenges faced by NHS Greater Glasgow and Clyde. This was one of a series of visits with all Boards being visited by the Chief Operating Officer. Mrs Grant highlighted the ongoing work to reduce the national cancer waiting time position, noting she continues to meet with the Board Chief Executives Group, alongside the Scottish Government, to discuss and agree short, medium and long term strategic plans in light of the increasing pressures. Mrs Grant Joined the Cabinet Secretary's visit to the Beatson to view the newly fitted MRI scanner that had been funded jointly by the Beatson Cancer Charity and the NHSGGC Endowment Fund. Mrs Grant also visited the Laundry Service at Hillington, and had the opportunity to speak with members of staff. Mrs Grant noted the tremendous work colleagues within the Laundry Service have done throughout the pandemic, and found their approach to their duties impressive. The Chair thanked Mrs Grant for the update and invited comments and questions from members. In response to a question about the communication of the de-escalation, Ms Sandra Bustillo, Director of Communications and Public Engagement, confirmed that a Core Brief was issued to all staff and the Senior Management Team at the QEUH and RHC were personally thanked for their efforts towards the de-escalation.		

			ACTION BY
	In summary, the Board were content to note the Chair's Report and the Chief Executive's Report. **NOTED**		
50.	**ANNUAL REPORT FOR THE BOARD OF NHSGGC AND THE AUDITOR GENERAL FOR SCOTLAND 2021/22**		
	The Board considered the paper 'Annual Report for the Board of NHSGGC and the Auditor General for Scotland' [Paper No. 22/31] which was presented by Ms Liz Maconachie, Audit Scotland. Ms Maconachie opened with thanks to the NHSGGC Finance Department, noting the good working relationships between Audit Scotland and NHSGGC. Ms Maconachie explained that the report considered an audit of the annual report and accounts, and consideration of the NHS Board's: • Financial management; • Financial sustainability; • Governance and transparency; and • Value for money. It was confirmed that report was also considered in full at the Audit and Risk Committee on 21 June 2022. Ms Maconachie explained that the financial impact of COVID-19 on the Health Board and the six Integration Joint Boards (IJBs) is estimated to be £284 million. All COVID-19 costs incurred during 2021/22 were funded by the Scottish Government (on a non-recurring basis). NHSGGC developed a one-year financial plan for 2022/23. The overall financial challenge identified was £173 million. However, the Financial Improvement Programme (FIP) for 2022/23 sets out a recurring savings target of £54 million. It was recognised that NHSGGC will be required to return to medium/long term financial planning for 22/23. In response to a question regarding the appropriate use of IJB reserves for COVID-19, Ms Maconachie assured the Board that processes were in place to ensure that these reserves were spent on COVID-19 related costs. Ms Miller confirmed that the		

			ACTION BY
	processes were clear in terms of the IJB reserves. Ms Carrigan highlighted that she continues to work closely with the IJB and Scottish Government to identify COVID-19 costs and how the reserves should be utilised. Rev Mathews noted his role as Chair on Renfrewshire IJB and reassured the Board that there were robust processes in place to discuss, and scrutinise, the use of these funds. Ms Maconachie explained that both organisations are subject to the same robust auditing process. In response to a query regarding the impact of the pay award on the total savings to be incurred, Mrs Grant highlighted that the FIP had incorporated the pay award into the money required to be saved. Mrs Grant also explained that additional funding would be received throughout the financial year which would help offset the pay award against the savings target. The Board were content to approve the report. **APPROVED**		
51.	**AUDIT AND RISK COMMITTEE UPDATE –**		
a)	**CHAIR'S REPORT OF MEETING HELD 21 JUNE 2022**		
	The Board considered the paper 'Chair's Report of ARC Meeting held on 21 June 2022' [Paper No. 22/44] which was presented by Mrs Margaret Kerr, Chair of the Audit and Risk Committee (ARC). Mrs Kerr highlighted that the ARC had met twice in June, with the meeting held on 21 June 2022 being used to scrutinise the auditor's report and recommendations. The ARC reviewed the Governance Statement to ensure that they were satisfied with the content, and were in agreement that this accurately reflected the work undertaken by the Board throughout the year. Mrs Kerr assured the Board that the ARC spent a significant amount of time reviewing the sources of assurance, and it was the Committee's recommendation to the Board that they are satisfied the processes were appropriate, and the accounts should be adopted. The Board were content to note the update. **NOTED**		

			ACTION BY
b)	**ANNUAL REPORT OF CONSOLIDATED ACCOUNTS FOR 2021/22**		
	The Board considered the paper 'Annual Report of Consolidated Accounts for 2021/22' [Paper No. 22/32] which was presented by Ms Jackie Carrigan, Assistant Director of Finance. Ms Carrigan noted that, following the ARC held on 7 June 2022, there were last minute changes to the report following an NSS notification related to the supply of LFD kits. These kits are supplied by the UK Government and the cost was £77.7M. It was agreed that this figure should be reflected within the accounts. Ms Carrigan explained that NHSGGC received £17.8M, however, this was reflected in the accounts as a donation so did not affect the overall position. Ms Carrigan was pleased to note that NHSGGC were successful in meeting the necessary targets, and noted the Remobilisation Plan (RMP) was submitted to Scottish Government in September 2021. The Board is currently finalising an Annual Delivery Plan for 2022-23 which is due to be submitted to Scottish Government by 31 July 2022. The Board agreed that the statement of accounts should be approved and signed by the Chief Executive. **APPROVED**		
52.	**GOVERNANCE STATEMENT**		
	The Board considered the paper 'Governance Statement 2021/22' [Paper No. 22/33] which was presented by Ms Jackie Carrigan, Assistant Director of Finance. Ms Carrigan reinforced that the Governance Statement had been reviewed by the ARC on 21 June 2022, and had a statement enclosed from the Chair of the ARC for assurance. The Board were asked to approve the statement to be submitted as part of the annual accounts. The Board were content to approve the Governance Statement. **APPROVED**		

			ACTION BY
53.	**PATIENT STORY**		
	Professor Angela Wallace, Nurse Director, introduced a short video presentation, which described Realistic Medicine and the positive impact that this has on our patients. The Chair thanked everyone who participated in the video presentation, with special thanks to the patients who had participated in the video. **NOTED**		
54.	**COVID-19 UPDATE**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 22/34] presented by Dr Emilia Crighton, Interim Director of Public Health. Dr Crighton noted that there had been an increase in positivity rates, and although we are now 'living with COVID', it was important to acknowledge that the numbers were increasing and the impact that this would have across our services. In response to a question regarding whether the increasing numbers of inpatients were as a result of COVID, it was noted that some of patients caught COVID during an inpatient stay, and other positive tests were incidental findings. Mr Edwards noted that the reality of a positive COVID test has a ripple effect across services due to infection control protocols, and highlighted that there were 10 wards closed across Acute Services, resulting in 53 beds unavailable for occupancy. Mr Edwards also noted that hospital occupancy within NHSGGC was above 95%, which is indeed very challenging. The high occupancy combined with a rise in COVID-19 related absence is a significant situation to manage on a daily basis. In response to a question regarding the impact of patient safety as a result of staffing levels/absence, Professor Wallace explained that there were staffing issues across NHS Scotland and that there has been ongoing work around workforce to ensure patient safety. It was noted that along with sickness absence, there were also vacancies. Professor Wallace assured the Board that the Senior Management Team work closely with Lead Nurses and Chief Nurses to ensure wards are safe. Mr Edwards also highlighted the Safe to Start meetings which are held every day across the clinical teams in each of the sectors.		

			ACTION BY
	These meetings assess each site with Lead Nurses across various points in the day to ensure planned absences are covered, however, he noted that unplanned absences can cause challenges. Mr Edwards assured the Board that the teams across the sites continually look to minimise risk and, if required, seek external support from other sites across the Acute Division. Mrs MacPherson highlighted that there was also a focus on staff wellbeing by ensuring appropriate breaks were being taken, annual leave was well utilised across the year and that our R&R hubs remain active for staff to take 'downtime', when needed. She also noted that staff have access to local Psychology Services as well as Occupational Health. NHSGGC also have an embedded peer support model in place, alongside the roll out of iMatter to give staff the opportunity to feedback concerns anonymously to their management teams. In response to a question regarding staffing levels at Inverclyde Royal Hospital, Ms Brimelow assured the Board that the Care and Clinical Governance Committee (C&CG) review safe staffing levels regularly and were aware that HIS had highlighted within their reports that staffing was an issue for NHS Boards. The C&CG will continue to monitor this and highlight any concerns around safety issues to the Chief Executive and Chief Operating Officer. Mr Vincent also highlighted that staffing levels have been subject to review via the Whistleblowing process, and was content that a lot of work had been done to provide assurance that staff safety levels were constantly under review. It was queried whether staff from the Lighthouse Lab could be redeployed to assist services under particular pressure. Mrs Grant explained that the responsibility of the Lighthouse Lab fell under the University of Glasgow, and the staff there were not NHSGGC employees. Mrs Grant noted that following the disbanding of the Test and Protect Service a number of staff members were redeployed to front line services to assist. It was noted that these staff members were subject to fixed term contracts which were due to end in September 2022, however, we continue to work with services to retain staff, where possible. In response to a question regarding the complacency within the community with regards to safeguarding against COVID-19, Dr Crighton noted that there is still access to COVID-19 testing kits, meaning the public can still perform tests before events or travelling. The message across NHS Scotland is based on a national campaign called 'Covid Sense'. There will also be the		

			ACTION BY
	autumn immunisation programme for people over 65, alongside care home and front line staff. Mrs Grant highlighted that there are also weekly bulletins to Board Members, MP and MSPs with updates on the COVID numbers within the hospitals. It was acknowledged that the NHSGGC Public Health and Communications Teams have done a good job at keeping the message in line with national guidance. The Board were content to note the update. **NOTED**		
55.	**PUBLIC HEALTH SCREENING PROGRAMME ANNUAL REPORT**		
	The Board considered the paper 'Public Health Screening Programme Annual Report' [Paper No. 22/35] presented by Dr Emilia Crighton, Interim Director of Public Health. The paper provided an overview of the screening programmes for the period 1 April 2020 to 31 March 2021. Dr Crighton explained that during 2020, as the result of the lockdown, screening programmes for adults were paused. Dr Crighton highlighted that all programmes are now back to delivering services in line with infection control guidelines. In response to a query regarding increasing engagement for cervical and bowel screening, Dr Crighton acknowledged that there is health inequality across all programmes and there has been research undertaken to establish how people engage and acknowledge the importance of screening. There have also been a number of campaigns to make attendance easier, for example reducing bowel screening from 3 tests to 1 test. Dr Crighton assured the Board that NHSGGC continues to engage with those communities showing reluctance to take part in screening. A query was raised regarding trends dating back to 5-10 years for comparison purposes. Dr Crighton explained that the screening programmes are subject to scrutiny and the data is available, so historical data can be included in future reports. Cllr McGinty expressed concern that the number of people attending for cervical screening had reduced, and that it is known that areas of deprivation are disproportionately impacted. Dr Crighton explained that the period of inactivity has skewed the numbers, and that invites had been issued to everyone eligible for		

			ACTION BY
	cervical screening in September 2020. Alongside this there are targeted national campaigns to encourage engagement. The Board were content to note the update. **NOTED**		
56.	**QUEEN ELIZABETH UNIVERSITY HOSPITAL (QEUH) AND ROYAL HOSPITAL FOR CHILDREN (RHC) UPDATE**		
	The Board considered the paper 'Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update' [Paper No. 22/36] presented by Mrs Jane Grant, Chief Executive. The paper provided the Board with an update on the activity which continues across all of the strands of work related to the QEUH/RHC. Mrs Grant noted that all the recommendations from previous reviews had been completed and this had positively contributed to the decision on the de-escalation of NHSGGC from Level 4 to Level 2. Mrs Grant highlighted that the Public Inquiry was ongoing, but the oral hearings originally scheduled for October/November 2022 had been postponed by Lord Brodie. Mrs Grant acknowledged the hard work and dedication of the Executive PMO team who are supporting the distribution of information for the Inquiry. The Board were content to note the update. **NOTED**		
57.	**NHSGGC BOARD PERFORMANCE REPORT**		
	The Board considered the paper 'Performance Report' [Paper No. 22/37] presented by Mr William Edwards, Chief Operating Officer. The paper provided the Board Members an update on performance against the key indicators as outlined in the Performance Assurance Framework. Mr Edwards highlighted the significant pressures across the Acute sites, as a result of COVID-19, and explained that the services are moving forward with the remobilisation of outpatients, and working towards improving the performance of		

			ACTION BY
	scheduled care, where possible. Mr Edwards assured the Board that we are maximising opportunities to deliver as much planned care activity as possible, despite high occupancy rates and unscheduled care demand, and there are action plans in place across the Acute Division to aid recovery. In response to a query regarding the performance indicators, Mr Edwards noted that the trajectories in place were in line with the Scottish Government Annual Delivery Plan, and our key priority is increasing outpatient activity while also looking to maximise planned care inpatient and day case activity. Mr Edwards highlighted that, although we are unable to deliver against current performance indicators, we will see an improvement as current trajectories were set and were not adjusted to reflect previous COVID-19 waves. Mrs Grant explained that it would be difficult to predict the trajectory as the situation remains fluid, noting that our current 95% occupancy rate remains very challenging. Mrs Grant assured Board Members that we are in regular dialogue with the Scottish Government regarding the challenges. In response to a question regarding GP Out of Hours (OOH) centres and the significant change in the number of presentations, Ms Manion highlighted that this was due to an increase in virtual/telephone advice. Ms Manion explained that the GP OOH service went into business continuity measures in response to COVID-19, which resulted in the model of delivery being changed. Ms Manion assured Board Members that the number of GP OOH sites remains the same. Due to the increase in virtual appointments, more GPs are able to support this system as opposed to physically covering OOH centres. Ms Manion highlighted that the model was reviewed regularly, and our Finance Planning and Performance Committee reviewed data relating to performance; including waiting time for call backs, waiting time at centres etc. The Board were assured that the system was having a positive impact, with GP advice being offered earlier which would impact on the numbers of patients attending A&E. In response to a query regarding the CAMHS waiting list, Mrs Grant explained that there is a balance between clinical need and those who have been on the waiting list for the longest amount of time. Mrs Grant assured Board Members that clinical need is what drives what we do, and part of this means that our patients should not be waiting a long time to be seen. Mrs Grant noted that there was work ongoing to increase resource within the		

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	CAMHS service, and the use of multidisciplinary teams to try and reduce the delays. Ms Manion explained that the trajectory was linked to workforce planning and that the crux of the issue was resourcing within the system. It was noted that resourcing within CAMHS is a national issue, and the national Workforce Plan was evolving alongside local plans to incorporate these challenges. Ms Manion highlighted that there is now the centralised recruitment process, alongside making roles attractive by including educational and career opportunities in an attempt to increase our resource across Mental Health, but in CAMHS in particular. **NOTED**		
58.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Health Associated Infection Reporting Template' [Paper No. 22/38] presented by Professor Angela Wallace, Nursing Director. The paper is a mandatory reporting tool for the Board to have an oversight of the Healthcare Associated targets, and the Board's performance of these. The report also includes any significant outbreaks or incidents across the Health Board. Prof Wallace highlighted that NHSGGC was in a stable position and paid her tributes to staff in clinical areas for their focus on Infection Control. Prof Wallace noted that the performance was stable, and improving, and that NHSGGC was in a good position nationally. The Board were reassured that the report was reviewed in depth at the CC&G Committee, with a whole system improvement network in place to further increase system safety. Prof Wallace explained that the targets have been brought forward for another 12 month reporting period across NHS Scotland due to the prevalence of COVID-19. Prof Wallace noted that there were 2 unannounced HIS visits to the QEUH (March and June); the March visit has been reported and is available for the public. Prof Wallace was pleased to note 6 areas of good practice, with positive feedback being received regarding the culture and leadership, particularly focussing on teamwork in line with the Infection Control guidelines. The June report is not yet available, but the initial feedback from the onsite visits has been largely positive. Prof Wallace highlighted that the teams are keen to improve safety for our patients and part of this is working alongside		

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	patients and families and indeed this is one of the key work streams within the Infection Prevention and Control Quality Improvement Network. **NOTED**		
59.	**ACUTE SERVICES COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF THE MEETING HELD 17 MAY 2022**		
	The Board considered the paper 'Chairs Report of the Meeting held 17 May 2022' [Paper No. 22/39] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 22 MARCH 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 22 March 2022' [ASC(M)22-02] and were content to note this. **NOTED**		
60.	**CLINICAL AND CARE GOVERNANCE COMMITTEE UPDATE**		
a)	**CHAIRS REPORT OF THE MEETING HELD 7 JUNE 2022**		
	The Board considered the paper 'Chairs Report of the Meeting held 7 June 2022' [Paper No. 22/40]. Ms Brimelow explained that the Committee were looking for assurance that the 'door to needle' time for the Thrombolysis and Thrombectomy Services was under review. Dr Armstrong assured the Board that NHSGGC were developing a Thrombolysis service within the Royal Alexandra Hospital (RAH), with a view to staff being training in this service by August 2020. The aim of introducing this service is to minimise the need for patients to be transported to the QEUH for treatment, therefore reducing the time without treatment. The Board were content to note this.		

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	NOTED		
b)	**APPROVED MINUTE OF THE MEETING HELD 1 MARCH 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 1 March 2022' [CCGC(M)22-01] and were content to note this. **NOTED**		
61.	**AREA CLINICAL FORUM UPDATE**		
a)	**CHAIRS REPORT OF MEETING HELD 9 JUNE 2022**		
	The Board considered the paper 'Chairs Report of the meeting held 9 June 2022' [Paper No. 22/41] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF THE MEETING HELD 21 APRIL 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 21 April 2022' [ACF(M) 22-02] and were content to note this. **NOTED**		
62.	**NHSGGC FINANCE REPORT**		
	The Board considered the paper 'NHSGGC Finance Report' [Paper No. 22/42] presented by Ms Jacqueline Carrigan, Assistant Director of Finance. The paper provided the Board with the Month 12 financial position, including the position of the Financial Improvement Programme (FIP) and the capital position. Ms Carrigan explained that the position was reflected in the annual accounts. She noted that 2022/23 work was underway with regards to the Financial Improvement Programme. Ms Carrigan highlighted that a workshop had taken place with Corporate Directors and Chief Officers regarding the savings requirement, and a follow up session would take place in August to develop and action plan. **NOTED**		

63.	**FINANCE PLANNING AND PERFORMANCE UPDATE**		
a)	**CHAIR'S REPORT OF MEETING HELD 14 JUNE 2022**		
	The Board considered the paper 'Chairs Report of the meeting held 14 June 2022' [Paper No. 22/43] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF MEETING HELD 5 APRIL 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 5 April 2022' [FPC(M)22-02] and were content to note this. **NOTED**		
64.	**AUDIT AND RISK COMMITTEE UPDATE**		
a)	**APPROVED MINUTE OF MEETING HELD 7 JUNE 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 7 June 2022' [ARC(M)22-01] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF MEETING HELD 15 MARCH 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 15 March 2022' [ARC(M)22-02] and were content to note this. **NOTED**		
65.	**STAFF GOVERNANCE ANNUAL REPORT**		
	The Board considered the paper 'Staff Governance Annual Report' [Paper No. 22/45] presented by Mrs Anne MacPherson, Director of HR and Organisational Development. The paper described the purpose and composition of the Staff Governance Committee, the business items considered, and key outcomes identified by the Committee during 2021/22. Mrs MacPherson highlighted that, despite the challenges of COVID-19, we had achieved our ambitions of ensuring the wellbeing and safety of our staff. It was noted that the Workforce Plan was critical in allowing staff to remain supported.		

	Mrs MacPherson explained that 75% of the Workforce Strategy had been achieved, and any actions not picked up would be reviewed in an action plan moving forward. Mrs MacPherson was pleased to note that the Investors in People programme has also been successful within Inverclyde Royal Hospital, and this would be rolled out across the other Acute sites in due course. This work is supported by the iMatter surveys, which is due to conclude in July 2022, and appropriate action plans will be developed across services, depending on staff feedback. Mrs MacPherson assured Board Members that the SGC continued to review education, training and wellbeing of staff, alongside whistleblowing themes and seek assurance from the whistleblowing processes being followed in line with the Standards. **NOTED**		
66.	**STAFF GOVERNANCE COMMITTEE UPDATE**		
a)	**CHAIR'S REPORT OF MEETING HELD 24 MAY 2022**		
	The Board considered the paper 'Chairs Report of the meeting held 24 May 2022' [Paper No. 22/46] and were content to note this. **NOTED**		
b)	**APPROVED MINUTE OF MEETING HELD 1 FEBRUARY 2022**		
	The Board considered the paper 'Approved Minute of the Meeting Held 15 March 2022' [SGC(M) 22-01] and were content to note this. **NOTED**		
67.	**OPERATIONAL PRIORITIES**		
	The Board considered the paper 'Operational Priorities' [Paper No. 22/47] presented by Mrs Jane Grant, Chief Executive. Mrs Grant explained that Operational Priorities were considered at a Board Seminar in March 2022. The Priorities are aligned to the 4 Corporate Aims of the organisation, and are designed to support delivery of the Corporate Objectives. Mrs Grant highlighted the size of the Health Board, and the importance of streamlining the objectives to ensure that they remained		

	manageable. In developing this year's priorities the focus has been on remobilisation and recovery, acknowledging the significant pressures during the pandemic and challenges moving forward. In response to a question regarding the reporting of achievements being met, Mrs Grant confirmed this would be reviewed by relevant Committees and considered within their own objectives. There will, however, be overall feedback brought to the Board in due course. The Board were content with the update and approved the Operational Priorities. **APPROVED**		
68.	**IMPLEMENTING THE ACTIVE GOVERNANCE APPROACH UPDATE**		
	The Board considered the paper 'Implementing Active Governance Approach – Update' [Paper No. 22/48] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance. The paper provided an update of the 'The Active Governance Programme April 2021 – March 2022' which had previously been approved. Ms Vanhegan noted that, despite significant challenges, there had been progress made in embedding the active governance approach. In terms of some of the outstanding actions Ms Vanhegan summarised the work in relation to the Strategic Planning Framework and also information flows to the Standing Committees. Further focus was being given to both aspects. The Board would receive an update on Board level reporting and, as regards strategic planning, the Finance Planning and Performance Committee would receive an update in October. Ms Vanhegan updated the Board regarding 'hybrid working' and what this meant for our Standing Committees. Ms Vanhegan met with the CEO, Chair, and Chairs of the Standing Committee Chairs Network in June 2022, where it was agreed that hybrid meetings should remain in place and the location of the meeting would be considered on a meeting by meeting basis, ensuring that infection control measures are adhered to throughout. Ms Vanhegan noted that the Active Governance approach is a dynamic process and as such would be incorporated into relevant action plans moving forward. A national self-assessment process is being developed and would be implemented in 2023.		

	Professor Brown updated the Board with regards to the second edition of the Blueprint of Good Governance, noting that a self-assessment should be completed at the end of financial year to allow each Board to reflect on outcomes, and develop action plans for areas of improvement. Prof Brown highlighted that this will become standard practice across NHS Scotland. The Board were content to approve the continuation of Hybrid working and note the update to the Active Governance approach. **NOTED**		
69.	**ANNUAL REVIEW OF GOVERNANCE**		
	The Board considered the paper 'Annual Review of Governance' [Paper No. 22/49] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance. Ms Vanhegan explained that the Annual Review of Governance papers had last been reviewed by Members at the September 2021 Board Meeting as a result of the impact of COVID-19, however, it was important that this was brought back in line for the approval of the annual accounts, which was why it was again being considered at the June Board. Ms Vanhegan explained that there were minor amendments to the Scheme of Delegation, which had resulted in minor changes to the Committee Terms of References. Ms Vanhegan noted that each Committee had reviewed and agreed their Terms of Reference before they had been included in the pack. Ms Vanhegan advised that the revised Model Code of Conduct for public bodies, (the Code), which had not been updated since 2014, was included within the Framework. The Code had been issued by the Scottish Ministers, with the approval of the Scottish Parliament, as required by the Ethical Standards in Public Life etc. (Scotland) Act 2000. Boards were previously requested to review and comment on the Code and members were reminded of the process undertaken to agree the final version. All Boards were asked to formally adopt the Code, confirming this to the Scottish Government and publishing it on their websites by the 10th June. This action was completed on time by NHSGGC and the new Code of Conduct for Board Members was now in place. Cllr McCluskey questioned the interpretation of para 3.11 of the NHSGGC Code of Conduct for Board Members that refers to the 'collective responsibility' of Board Members. Following discussion around this issue, in particular how this might impact on Board		

	Members who are also Local Authority Councillors, the consensus was reached that the paragraph in question should remain in place and any difficulties that this might cause for Board Members in their work as Councillors would have to be raised by them with the Scottish Government via COSLA. Mrs Kerr acknowledged the amount of hard work that had gone into producing the Governance Framework document and bringing the timeframe back in line with the annual accounts. Prof Brown also noted the evidence of a high standard of governance within NHSGGC. **APPROVED**		
70.	**REVIEW OF GOVERNANCE COMMITTEE AND INTEGRATION JOINT BOARD MEMBERSHIP**		
	The Board considered the paper 'Review of Governance Committee and Integration Joint Board Membership' [Paper No. 22/50] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance. Ms Vanhegan explained that, as Chair of the Board, Professor Brown reviews the membership of the standing committees, and IJBs, at least annually, however, more frequently as and when vacancies arise. The amendments to membership are in line with succession planning, with some Chairs coming to the end of their tenure. Ms Vanhegan noted that this process included the balance of capacity, alongside the Member's skillset. Prof Brown highlighted that the membership was subject to change following Board Member induction which was scheduled to take place in July. The Board were content to approve the Board Member Committee & IJB Allocation. **APPROVED**		
71.	**ANNUAL CYCLE OF BUSINESS**		
	The Board considered the paper 'Annual Cycle of Business' [Paper No. 22/51] presented by Ms Elaine Vanhegan, Director of Corporate Services and Governance. Ms Vanhegan explained that it is important that the Annual Cycle of Business is reviewed routinely to ensure that the business is aligned to the corporate aims and objectives.		

	NOTED		
72.	**VALEDICTORIAN**		
	Prof Brown highlighted that it was Ms Susan Manion's last meeting with the Board as she retires from her role at the end of June. Prof Brown thanked Ms Manion for her contribution over the years, and wished her well with her retirement.		
73.	**DATE OF NEXT MEETING**		
	The next meeting would be held on Tuesday 23 August 2022 at 9.30 am via MS Teams		

NHS Greater Glasgow and Clyde	**Paper No. 22/36**
Meeting:	**NHS Board**
Date of Meeting:	**28 June 2022**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Tom Steele, Director of Estates and Facilities Elaine Vanhegan, Director of Corporate Services & Governance**
Report Author:	**Elaine Vanhegan, Director of Corporate Services & Governance**

1. Purpose

The purpose of the attached paper is to:

Update the Finance Planning and Performance Committee on the positon regarding the Queen Elizabeth University Hospital and Royal Hospital for Children in respect of;

- The Oversight Board and Case Note Review Report
- The Public Inquiry
- The Police Investigation
- The Legal Claim.
- The Rectification Programme

2. Executive Summary

The paper describes the significant activity which continues across all of the strands of work related to the QEUH/RHC.

3. Recommendations

There are no formal recommendations within the paper.

4. Response Required

This paper is presented for **awareness**.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- Better Health **Positive**
- Better Care **Positive**
- Better Value **Negative**
- Better Workplace **Positive**
- Equality & Diversity **Neutral**
- Environment **Positive**

6. Engagement and Communication

The issues described within the paper are subject to wide engagement across the organisation with each aspect led by a Corporate Director.

7. Governance Route

The issues described have been considered by the Executive Oversight Group and the Corporate Management Team, both chaired by the Chief Executive and the finance Planning and Performance Committee.

8. Date Prepared and Issued

Date prepared: 17 June 2022.
Date issued: 21 June 2022.

NHS Greater Glasgow and Clyde	**Paper No. 22/35**
Meeting:	**NHS Board**
Date of Meeting:	**28 June 2022**
Title:	**QEUH/RHC Update**
Sponsoring Director/Manager:	**Tom Steele, Director of Estates and Facilities Elaine Vanhegan, Director of Corporate Services & Governance**
Report Author:	**Elaine Vanhegan, Director of Corporate Services & Governance**

1. Introduction

This paper is presented to the Board to update members on the position regarding a number of issues related to the Queen Elizabeth University Hospital (QEUH) and the Royal Hospital for Children (RHC). It is provided for the purposes of information and assurance.

2. Background

The Board will be familiar with the issues in respect of the QEUH and RHC, subsequent to Level 4 Escalation on the Scottish Government's Performance Framework, the lodging of legal action against Multiplex, Currie & Brown and Capital, the Scottish Hospitals Public Inquiry and the Police Investigation. The HSE Appeal is currently sisted. This paper provides an update.

3. Assessment

3.1 Oversight Board

Board members will be aware, that on the 13th June, the Chief Executive was notified by the Director-General of Health & Social Care and Chief Executive NHS Scotland, Ms Caroline Lamb, that the Board was de-escalated to Level 2 on the NHS Scotland Performance Management Framework. This is an important milestone for the Board and it is a testament to the hard work and support of many staff.

Despite the challenges faced throughout the COVID-19 pandemic, all of the improvements identified in the 108 recommendations from the respective reviews,

have been delivered. The work of the frontline staff on the Schiehallion Ward at the RHC and our Infection Prevention and Control and Estates and Facilities teams has illustrated significant commitment and dedication to support our patients and their families at all times.

The Board will continue to focus on embedding recommendations ensuring continuous improvement.

3.2 Public Inquiry

The Scottish Hospitals Public Inquiry (the Inquiry) was launched in August 2020. The first substantive hearings of the Inquiry commenced on 20 September 2021 and concluded on 14 November 2021. The oral evidence was provided by families and patients affected by the issues being explored by the Terms of Reference of the Inquiry. Further hearings were held in May 2022 mainly in respect of NHS Lothian with the first week focussing on the Theory and Practice of Ventilation. This was explored at a high level and the Inquiry did not, at this stage, apply any of the principles of ventilation to the QEUH. As such, there were no specific issues for the Board arising from this chapter of evidence. There is likely to be a more focused examination of ventilation arrangements at the QEUH in future evidential hearings

The dates for the next diet of oral hearings relating to the Queen Elizabeth University Hospital and the Royal Hospital for Children were scheduled for 14 October to 2 December. However, the Board were notified on 9 June that these hearings, as well as hearings scheduled for Lothian in October, were being postponed. Further information is awaited.

Significant activity continues responding to the Inquiry's approach to requesting information (RFIs). These come in themed tranches, looking for both narrative explanations to specific questions, as well as the provision of key documents. Due to the volume of work requiring active co-ordination, an Executive Working Group has been established reporting to the Executive Oversight Group, which continues to meet weekly.

The Witness Engagement and Support Team (WEST) of the Inquiry have made contact with a number of key individuals within NHSGGC, with our Witness Support process engaged in this element of the work focussing on the welfare of our staff. GGC Counsel have also been consulting staff in preparation for future hearings.

3.3 Police Investigation

Police Scotland continue their investigation in respect of four deaths at the QEUH/RHC. We continue to work in a collaborative manner with the Senior Investigating Officers in order to ensure staff are supported, with a single point of contact through which requests for staff access/interview and information can be made. This is in keeping with the Board's current processes with a Witness Support Officer in place. Staff are advised to contact our Witness Support Officer for advice and support. Guidance for staff is available with the welfare of our staff paramount whilst still engaging with the investigation acknowledging the many other strands underway.

3.4 Civil Claims

The Board has now received 28 intimations of claim in respect of QEUH and RHC. There is close working between the PMO and CLO on the related themes, however at this stage all cases are currently sisted.

3.5 The Legal Claim

The first legal summons to defenders Multiplex Construction Europe Limited, BPY Holdings LP, Currie and Brown UK Ltd, and Capital Property and Infrastructure Ltd was lodged on 22nd January 2020. Lord Tyre heard legal debate on the matter of interrupted time bar and found in favour of NHSGGC, rejecting the defender's position that the action was incompetent and should be dismissed. The Court has subsequently refused Multiplex and Capita's motion for permission to appeal Lord Tyre's decision. There remains a possibility of an appeal at a later stage when all the merits of the case have been determined. The court has now sisted the action to allow for the claims to be adjudicated and a regular exchange of information continues to prepare for adjudication. Additionally, consideration is being given to engaging directly with Multiplex on a number of the issues. Two further court summons have been served on Multiplex and their Parent Company. The chilled water system, served first in April 2021 has now been sisted by the court at the agreement of the defenders. The summons in relation to internal cladding issues was served in March 2022**.**

3.4 QEUH/RHC Rectification Programme

A contractor directly appointed by NHSGGC, is well advanced with pre-construction activities for the Adult Atrium Cladding and works will commence on site in July. Briefing and pre-construction design activities have commenced with the Board appointed contractor on various rectification workstreams including: the ETFE roof, improvements to the energy centre performance, glazing remediation and the feasibility of further ventilation improvements. Multiplex have not yet formally withdrawn from the request that they remedy the defect in relation to the failure of the atrium roof hot wire system. NHSGGC continue to meet regularly with statutory authorities and advisors, including Scottish Fire and Rescue Service, Scottish Government and Glasgow City Council Building Standards, to inform and assist with risk management and emerging legislative guidance.

4. Conclusions

The Executive Oversight Group (EOG) continue to meet weekly to oversee all aspects described in relation to the QEUH and RHC. The Senior Team remain clear that focus is required to ensure effective response to the many demands, as well as ensuring patients, families and staff are supported.

5. Recommendations

No specific recommendations.

6. Implementation

Implementation and ongoing work has been detailed in Section 3.

7. Evaluation

This is not applicable at this stage.

8. Appendices

There are no appendices.

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 37 – Board Minutes and Relevant Papers

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