SCOTTISH HOSPITALS INQUIRY

Bundle of document for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 42 – Volume 8

Previously Omitted NHS GGC Board Minutes

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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 August 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
Councillor J Coleman
Dr D Colville
Mrs A Coultard (to Minute 82)
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
Mr I Lee
Councillor J McIlwee
Councillor D MacKay
Mr G McLaughlin
Mrs R K Nijjar
Councillor I Robertson
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

Dr S Ahmed	..	Clinical Director – Public Health Protection Unit
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr R Calderwood	..	Chief Operating Officer, Acute Services Division (to Minute 84)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Mental Health Partnership
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Mr T Walsh	..	Infection Control Manager

ACTION BY

77. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Dr L de Caestecker, Professor D Barlow, Mr R Cleland, Councillor J Handibode, Ms J Murray and Dr B Cowan.

Mr Robertson welcomed Mr I Lee, Non-Executive Member, to his first Board meeting.

78. CHAIR'S REPORT

(i) Mr Robertson paid his tribute to the late Professor Tim Cooke who tragically died in a recent car accident. Professor Cooke was the Associate Medical Director of Surgery and Anaesthetics, Acute Division and would be greatly missed by his colleagues within NHS Greater Glasgow and Clyde. The Chairman, on behalf of the Board, had written to Professor Cooke's family expressing deepest regret and sympathy.

ACTION BY

(ii) On 3 July 2008, Mr Robertson attended the openings of the West of Scotland Regional Heart and Lung Centre and Milngavie Water Treatment Works by HM the Queen.

(iii) On 5 July 2008, Mr Robertson had attended the NHS 60th Anniversary event at the Royal Concert Hall. This had been an excellent event providing memories of the NHS throughout the sixty years as well as providing the heart warming opportunity to conduct the NHS Greater Glasgow and Clyde Diamond Awards.

(iv) On 21 July 2008 and 8 August 2008, Mr Robertson had visited the Vale of Leven Hospital. He had been pleased to get a conducted tour of the hospital itself and meet with staff there. Mr Robertson paid tribute to the hard work, commitment and dedication of the staff which was very much evident.

(v) On 18 August 2008, the Cabinet Secretary for Health and Wellbeing had chaired the Board's Annual Review. The event was held at the Royal Concert Hall and was well attended. Initial early feedback had been positive.

NOTED

79. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers referred to press coverage that morning around concerns expressed about the length of time that had elapsed before the removal of deceased patients from the ward where they had died. In both cases, respecting specific requests made by family members had been one factor which had contributed to the delay. An audit of all hospital facilities across the Acute Division would be conducted particularly of mortuary facilities (focussing particularly on their capacity and standard of viewing rooms). Mr Calderwood described how, following completion of the Board's modernisation programme, 60% of beds would be provided within single rooms. In the interim period, however, single room provision would be audited to establish how they were currently being utilised and to identify any improvements that could be made. Similarly, the audit would look at multiple occupancy rooms in an attempt to establish any improvements that could be made to ensure patient privacy and dignity. In tandem with this, the Board's policies regarding the interaction with families following bereavement would be updated with revised guidance incorporated.

Mr Divers confirmed that Mrs Hawkins, Director, Mental Health Partnership, would undertake a similar audit in respect of all mental health inpatient facilities throughout the Board's area. Following these audits, Mr Divers agreed to advise Members of the outcome. **Chief Executive**

(ii) Discussions continued with senior managers from the St Margaret's of Scotland Hospice and the Board. Two detailed pieces of work had been agreed as well as work around financial costings of modelling. The debate and dialogue would continue and Mr Divers anticipated he would be in a position to report further to the Board at its October meeting. **Chief Executive**

ACTION BY

(iii) Mr Divers referred to the two separate reports that had been published following an outbreak of Clostridium difficile (Cdiff) at the Vale of Leven Hospital. The first was the findings from the Independent Review Panel into the Vale of Leven outbreak and the second was a national report from Health Protection Scotland.

Both had clear implications for the whole of NHSGGC. Senior management would ensure that the issues of leadership, governance and accountability were fully addressed and would work with staff to take forward a programme of improvements, including greater empowerment for charge nurses in regard to hospital acquired infections. A detailed action plan would now be prepared to address all the recommendations of the Independent Review Panel. He explained that the uncertainty over the future of the Vale of Leven Hospital had been a factor in the lack of major modernisation investments. Mr Divers gave his commitment that the Board would bring forward proposals in September which would set out a clear vision for the future of the Vale of Leven site that could then be subject of public debate over the next few months.

Mr Divers led the Board through a short presentation outlining the actions (and lead senior officers) that would ensure the work to complete the recommendations within the action plan in terms of governance, facilities, clinical leadership, surveillance, education, communication and finance. The completion target date for all bar one of the recommendations was the end of 2008. As such, it was his intention to provide monthly updates regarding progress on the totality of the action plan to the Performance Review Group, Clinical Governance Committee and Board meetings in line with the programmed cycle of these meetings

Medical Director

Chief Executive

Mr P Hamilton asked why the work on finance, specifically, charge nurses having access to resources to address urgent estates shortcomings and replacement of equipment had a target date of April 2009. Mr Calderwood explained that, at the moment, maintenance budgets were not allocated to that level of staff. Relevant Schemes of Delegation would require to be introduced as would new ways of allocating resources across Directorates so as to ensure that the relevant staff could access resources when required.

In response to a question from Ms Dhir, Mr Divers confirmed that the families of those patients who had been interviewed by the Independent Review Panel would be invited to be represented in the process to implement the recommendations. This would be built-in through the communication process, either directly or via patient focus public involvement (PFPI) or local Public Partnership Forum arrangements.

Mr Daniels referred to the report of the Independent Review Panel and, in particular, the general terms in which it was written. He welcomed the action plan that had been compiled and, in particular, the clear identification of the senior staff involved in taking these actions forward.

NOTED

80. MINUTES

On the motion of Mr P Hamilton, seconded by Mrs E Smith, the Minutes of the meeting of the Board held on Tuesday, 24 June 2008 [NHSGG&C(M)08/4] were approved as an accurate record and signed by the Chairman.

NOTED

ACTION BY

81. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted.

NOTED

82. PROPOSED CHANGES TO MATERNITY SERVICES IN CLYDE : OUTCOME OF CONSULTATION

A report of the Chief Operating Officer (Acute Services) and Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/35] asked the Board to note the outcome of the consultation process on proposed changes to maternity services in Clyde and the responses received. Furthermore, the Board was asked to support the continued provision, for the next three years, of midwife-led birthing services at the community midwifery units (CMUs) in Inverclyde Royal Hospital (IRH), the Vale of Leven Hospital (VoL) and the Royal Alexandra Hospital (RAH). During this period there would be a positive publicity campaign to encourage use of the Units and birth suite activity would be monitored.

Ms Byrne led the Board through the paper setting out the conclusions of the consultation process that had been undertaken. She explained that the initial review of maternity services within Clyde was undertaken during 2006 and 2007. A paper summarising the findings of the review (and the engagement process on which it was based) was submitted to the Board at its meeting in June 2007. This was followed by a period of independent scrutiny which considered the findings of the review and the wider review process. Formal consultation, taking account of the Independent Scrutiny Panel findings, was launched on 27 March 2008 and initially scheduled to finish on 19 June 2008. This period was extended to 27 June 2008 to enable all interested parties to respond.

Ms Byrne summarised the findings of the review process and the proposals put forward for full consultation including reference to the Independent Scrutiny Panel findings and recommendations. Based on these findings and following a review of options, the preferred option presented for public consultation was to close the birthing service at the Inverclyde Royal Hospital and Vale of Leven CMUs and move to a single midwifery-led birthing unit at the Royal Alexandra Hospital. All antenatal and postnatal services currently provided at the CMHs would continue to be provided.

Over and above this option, views were also sought on the three other options considered during the review, as follows:

- Status Quo
- Retain local births at all units through an on-call shift pattern at VoL and IRH
- Retain local births at all units through caseload management at VoL and IRH

Mr Calderwood explained that the driver of the proposed change to services was predominantly financial. There were no immediate clinical sustainability or safety concerns in relation to the community midwifery service, although it was acknowledged that the transfer rates during labour from IRH and VoL to RAH were significantly above the national average. He summarised the key themes resulting from the consultation and led the Board through the results of an audit of women receiving antenatal and postnatal care at the units which set out the key factors that influenced the mother's choice of where to give birth.

ACTION BY

Mr Calderwood noted that the recommendation presented to the Board was different from the preferred option that was presented for public consultation. He was conscious of the possibility that heightened publicity might promote greater use of the VoL and IRH CMUs and was not prepared to encourage any steps which might prejudice their longer term retention in the event of such strongly expressed demand. It was, therefore, recommended that the Board retain the units for three years to allow a determination on whether a combination of currently increasing activity, a greater local understanding and acceptance and increased demand from women to undertake subsequent pregnancies in the local CMU would lead to an increase in activity. An improvement in the underlying health status of mothers, making an increased number eligible for a CMU birth, would also be a factor. Increased numbers of births would clearly make the services more cost effective.

Furthermore, in the context of increasing actual and potential demand for birthing services, there were a number of other reasons why it was recommended that the Board sustain the birthing services at the VoL and IRH. The Board's partnership working with the Local Authorities sought both to improve the health and wellbeing of the communities and support economic regeneration activities. It was suggested during the consultation period that successful regeneration would lead to increased numbers of people moving to the Inverclyde and Vale of Leven areas and that this, in turn, would potentially lead to increased demand for CMU births.

The levels of activity would be carefully monitored over the next three years and should activity levels not increase to appropriate levels set out then a further review would be undertaken driven by the continued need for the Board to ensure services represented the best use of public resources.

Mr Williamson commended the outcomes from this consultation which had clearly been inclusive of partners and local communities. Although recognising that levels of activity would be carefully monitored over the next three years, he sought inclusion of clinical outcomes being similarly monitored. Ms Byrne confirmed that this would be the case and ongoing clinical audit would be important in ensuring safe sustainable services. Both Councillors McIlwee and Robertson welcomed the report and particularly the attempts it had made to understand the dynamics of the community. Councillor Robertson offered, on behalf of the Local Authority, to be involved in the public engagement activities to assemble and implement a communications plan quickly to promote increased usage of the CMUs. In this respect, Councillor Yates asked how success would be measured in terms of the proposed marketing campaign. Mr Calderwood responded by confirming that an appropriate increase of usage would result in increased financial viability which would bring into line the volume of births through the units with that across other services in NHSGGC.

As Chair of the Inverclyde Community Health Partnership (CHP), Mrs Smith commended the proposals and recognised the positive impact this would have on the local community, particularly in building good working relationships with trust and respect.

In response to a question from Mr Lee, Mr Divers confirmed that although the targets were challenging, an annual report on progress would be considered by the Board throughout each of the three years of monitoring.

DECIDED:

- That the outcome of the consultation process and the responses received to the proposed changes to maternity services in Clyde be noted.

ACTION BY

- That the continued provision, for the next three years of midwife-led birthing services at the Community Midwifery Units (CMUs) in Inverclyde Royal Hospital (IRH), the Vale of Leven Hospital (VoL) and the Royal Alexandra Hospital (RAH) be supported.

Chief Operating Officer/Director of Acute Services Strategy, Implementation and Planning

- That during this three year period there be a positive publicity campaign and birth suite activity would be monitored and be the subject of ongoing audit.

Chief Operating Officer/Director of Acute Services Strategy, Implementation and Planning

83. MODERNISING AND IMPROVING MENTAL HEALTH SERVICES ACROSS CLYDE : OUTCOME OF PUBLIC CONSULTATION

A report of the Director, Mental Health Partnership [Board Paper No 08/36] asked the Board to endorse four proposals for significant service change for submission to the Cabinet Secretary for Health and Wellbeing for approval. Furthermore, the Board was asked to note further work being undertaken to explore mental health proposals in the light of issues raised through the public consultation, and confirm its support for the various wider service change proposals summarised in the paper.

Mrs. Hawkins explained the background to the multi-agency Clyde Strategy Group which co-ordinated the process to develop a service strategy for modernising mental health services. As part of this process, local planning groups were tasked with the development of local proposals within the agreed strategic framework. The Board approved the Modernising Mental Health Services Strategy as the basis for public consultation in July 2007. Subsequently, the Scottish Government established a process of independent scrutiny and in December 2007, the Board considered a report setting out the Independent Scrutiny Panel (ISP) findings and the Board's response and commitments in light of the ISP recommendations. The further work to respond to the issues raised by the ISP and the public consultation documentation was completed by April 2008 with the public consultation process running from 9 April to 2 July 2008. That further work included commissioning an Independent Consultant to manage a process of option appraisal (as recommended by the Independent Scrutiny Panel) to inform the final proposals for public consultation. The option appraisal process broadly confirmed that the previously developed proposals remained those preferred, albeit with some refinement to the detail within the options.

Ms Hawkins led the Board through the logic of the consultation proposals and summarised the significant service change subject to public consultation. She set these in the context of the recommendations from the Independent Scrutiny Panel as well as linking them with the responses received to the consultation. Given the very different responses, she outlined them in terms of South Clyde, North Clyde and specialist services. She summarised feedback as follows:

- The proposals for South Clyde were broadly welcomed with only a small number of responses directly challenging the proposals and the majority of comments being more about detailed practical considerations to be taken into account within the implementation process.

- The proposals for specialist services commanded a high level of support with only a small number of responses directly challenging the proposals.

ACTION BY

- The proposals for North Clyde commanded a low level of public support in terms of the proposals to transfer inpatient services currently provided from Christie and Fruin Wards at the Vale of Leven to Gartnavel Royal The public were concerned to see any proposals for mental health assessed and located within an articulated vision for the future of services located at the Vale of Leven site.

Mrs Hawkins went through, in detail, the key themes arising from the consultation and, for completeness, highlighted the Board's response to these. For clarity, she summarised the conclusions and recommendations as follows:

- It was recommended that the proposal to transfer low secure learning disability forensic services from Dykebar Hospital to Leverndale Hospital be submitted to the Cabinet Secretary for approval.

- It was recommended that the Board approve the transfer of IPCU services from Dykebar Hospital to Inverclyde and Leverndale Hospitals.

- It was recommended that the Board approve the transfer of IPCU services for North Clyde from Lochgilphead Hospital to Gartnavel Royal Hospital.

- It was recommended that the Board approve the consolidation of South Clyde and South/West Glasgow addiction inpatient services at Leverndale Hospital.

- It was recommended that the Board approve the retention of Rowanbank as the provider of medium secure inpatient services for the West of Scotland (including Argyll and Bute catchment) on a permanent basis.

- It was recommended that the Board approve the development of low secure adult mental health forensic services for Clyde at Leverndale Hospital.

- It was recommended that the Board approve the development of intensive rehabilitation inpatient services for South Clyde at Dykebar Hospital with access to these services for East Renfrewshire at Leverndale Hospital and for West Dunbartonshire at Gartnavel Royal Hospital.

Councillor Yates sought clarity around one of the responses received that concerned access to community psychiatric nurses for custodial services. Ms Hawkins explained that currently court services within Glasgow have access to community psychiatric nurses but, to date, this service was not available at the court in Greenock.

Councillor Robertson broadly welcomed these proposals, in particular, the decision to link discussion about the future of the services provided in Christie and Fuin Wards to the forthcoming "vision" paper promised on overall service sustainability at the Vale of Leven Hospital. Councillor MacKay agreed and commended the improvement of services for local clients.

DECIDED:

- That the following four proposals for significant service change be submitted to the Cabinet Secretary for Health and Wellbeing for approval:

    - Replacing a significant number of adult mental health continuing care beds at Dykebar Hospital with alternative forms of care accommodation and support in the community.

Director, Mental Health Partnership

ACTION BY

- Transferring adult acute mental health admission beds from the Royal Alexandra Hospital to more modern, purpose built, single room accommodation at Dykebar Hospital. **Director, Mental Health Partnership**

- Re-providing older people's mental health continuing care beds from Dykebar Hospital to higher quality accommodation within an NHS Partnership bed model with the independent sector. **Director, Mental Health Partnership**

- Transferring low secure learning disability forensic services from Dykebar Hospital to Leverndale Hospital **Director, Mental Health Partnership**

- In light of responses and feedback from the consultation, the Board endorse the proposed commitment to consult on the Board's vision for the future of the Vale of Leven site and that consultation on the various elements, including in-patient mental health, should be integrated within that process. Furthermore, the Board noted further work being undertaken to explore the mental health proposals in light of the issues raised through public consultation. **Director, Mental Health Partnership**

- The Board confirmed its previous support for the various wider service change proposals, beyond those subject to the statutory public consultation process, whilst noting that the range of detailed and practical implementation issues raised would be proactively managed through the local implementation processes. **Director, Mental Health Partnership**

Mr Divers took the opportunity to provide an update on the development of a vision for future service provision at the Vale of Leven Hospital with particular regard to the retention of services and provision of new services. He presented to the Board a summary of current service provision and noted these in terms of patient episodes, totalling 115,000 attendances per annum.

Birthing services at Inverclyde and the Vale of Leven Hospitals would be sustained for three years, supported by a communications campaign to increase utilisation. Furthermore, a full range of post and antenatal services would continue to be delivered.

With regard to Clyde-wide mental health services, Mr Divers referred to Mrs Hawkins' earlier presentation and re-emphasised that the bulk of the strategy was non-contentious with a clear way forward accepted for South Glasgow. In respect of frail elderly/elderly mental health, there may be potential to use spare accommodation attached to the Fruin Ward, with minor upgrading to achieve a better mix of patient groups, as well as examining potential for linkages with frail elderly and rehabilitation services.

Mr Divers referred to the report of the external experts which looked at unscheduled medical care. They had concluded that many selected GP assessed admissions and self-presenting cases were likely to be able to be managed in a GP-supported unit. Anaesthetics, however, was not sustainable. Detailed protocols and staffing models would be taken forward during the pre-consultation period, alongside a more detailed review of existing attendances at the Medical Assessment Unit which would allow a firm estimate of the future caseload to be set out in the formal consultation paper

In addition to the care home development, plans had also been developed for a new Alexandria Medical Centre. Estimated capital costs were around £ 18m and a draft Outline Business Case was almost ready for submission. Full planning permission had been granted to develop the Centre on the Vale of Leven site and this would become part of the overall Vale campus and increase integration of primary and secondary care.

ACTION BY

Finally, Mr Divers summarised opportunities for possibly bringing additional services to the site especially regional specialist services (oral/dental health), additional dialysis capacity and medical and surgical specialties (urology, rheumatology and gastroenterology).

Mr Divers anticipated that a final set of proposals covering all future aspects of service sustainability for the Vale of Leven site, including unscheduled medical care should be ready for consideration by the Board in September 2008. **Chief Executive**

Councillor Robertson welcomed the presentation and, in particular, recognised this as an area where partnership working had ensured aspirations for services were being developed in a shared way contributing to the wider picture. Ms Dhir echoed this view and recorded her appreciation regarding the future vision for the Vale of Leven campus and hoped this would be reassuring to staff and patients within the local community.

Councillor MacKay was mindful of the recent publicity regarding the Vale of Leven Hospital and hoped that any uncertainty was removed and replaced now with confidence. He looked forward to receiving further financial information that would support the proposals discussed earlier. In response to this, Mr Divers noted that it remained important to get the Board's Financial Recovery Plan for Clyde balanced.

In response to a question from Mrs Stewart regarding the GP supported unit, Mr Divers explained that discussions and protocols would be developed to determine the case mix. These would take place as the engagement and pre-consultation proceeded. He confirmed that given the heavy dependence on GPs, full consultation would take place with the Board's Area Medical Committee and Local Medical Committee to ensure that all key interests were fully engaged in a proactive way. An early meeting had already been arranged with senior officers from NHS Highland to ensure that they were fully involved in the development of the proposals.

The Chair summarised the discussion and welcomed the recognition of the interdependency of the services to be provided at Vale of Leven campus. He looked forward to receiving further information at the September Board meeting.

NOTED

84. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No 08/38] asked the Board to note progress against the national targets as at the end of June 2008.

Mr Calderwood led the Board through progress across the single system towards achieving waiting time and other access targets set by the Scottish Government Health Directorates – commonly known at HEAT Targets.

In response to a question concerning delayed discharges, Mr Calderwood outlined examples of the complex cases that often could not be resolved within the target timescales. Although this was disappointing, Mr Daniels commended the Board's efforts at addressing delayed discharges. Mr Calderwood reassured the Board that he was working with neighbouring Local Authorities, particularly those who had reported funding difficulties, to resolve these issues.

NOTED

ACTION BY

85. WINTER PLAN 2008/09 – PROGRESS REPORT

A report of the Director of Acute Services Strategy Implementation and Planning [Board Paper No 08/37] asked the Board to receive an update on winter planning for 2008/09 which included reference to lessons learned from 2007/08.

Ms Byrne summarised some of the lessons learned from 2007/08 including effective communication, information sharing, escalation plan/senior decision making rota, occupational health and innovation.

As was the case with the 2007/08 Winter Plan, the 2008/09 Winter Plan would be co-ordinated by a system-wide Winter Planning Group and, in addition, an Executive Group with representation at senior level from across the key organisations. It would be important to put in place any relevant initiatives to stem the increase in activity and also be clear about the expectation of target delivery across all parts of the organisation. Historically, planning had focussed on pressure periods over the winter months due to a number of reasons; increase in cold/influenza type viruses; and adverse weather. It was becoming increasingly more common, however, for peaks in activity to happen all year round. This was one of the reasons why it was decided to continue with the Winter Planning Group and Executive Group all year round. Target delivery remained a priority twelve months of the year.

Ms Byrne acknowledged that, in 2007/08, Christmas Day and New Years Day fell on a Tuesday helping ease the pressures in the system as GP surgeries, pharmacies and other support services worked as normal on both Mondays. This was seen to be the main contributory factor to dealing successfully with pressures over the festive period. In 2008/09, however, the two public holidays each week would run immediately before a weekend, effectively meaning a four day "out of hours" period. Ms Byrne advised that NHS Greater Glasgow and Clyde had hosted a Regional West of Scotland event in July 2008 where that message had been reinforced. A national event would be held on 23 September 2008 at which NHS Greater Glasgow and Clyde and partners would be well represented.

Ms Byrne also highlighted additional resource requirements associated with putting in place initiatives to address acute pressures

DECIDED:

- That an update on Winter Planning for 2008/09, which included reference to lessons learned from 2007/08 and the work underway in developing the 2008/09 Winter Plan be received. **Director of Acute Services Strategy, Implementation and Planning**

- That the Winter Plan for 2008/09 be submitted to the Board meeting in October 2008. **Director of Acute Services Strategy, Implementation and Planning**

86. FINANCIAL MONITORING RPEPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2008

A report of the Director of Finance [Board Paper No 08/39] asked the Board to note its financial performance for the first three months of the financial year.

Mr Griffin highlighted that the Board, and its Operational Divisions, were currently reporting a breakeven outturn position against its revenue budget after the first three months of the year. The Board continued to forecast a revenue breakeven position for 2008/09.

ACTION BY

Mr Griffin led the Board through the details of expenditure to date against the Board's 2008/09 capital allocation and highlighted the progress report on achievement of the Board's 2008/09 cost savings target.

The Board continued to implement a three year cost savings plan in respect of the recurring deficit within the Clyde area of its management responsibilities. For 2008/09, the Board had reached an agreed position with the Scottish Government Health Directorate regarding how the residual gap of £12m would be addressed.

Mr Sime asked what measures were being put in place to counter increasing energy costs. Mr Griffin outlined the measures being taken at Board level and explained that the Scottish Government were negotiating, on behalf of all public organisations, a Government-wide initiative to minimise energy costs. The NHS would play into that process. Mr Griffin explained that currently the Board pays a total of around £30m per annum on gas and electricity. There could be an additional £1m per month between October 2008 and March 2009.

NOTED

87. INVOLVING PEOPLE COMMITTEE MEETING MINUTES : 2 JUNE 2008

The Minutes of the Involving People Committee meeting held on 2 June 2008 [Board Paper No 08/40] were noted.

NOTED

88. CLINICAL GOVERNANCE COMMITTEE MEETING MINUTES : 3 JUNE 2008

The Minutes of the Clinical Governance Committee meeting held on 3 June 2008 [CGC(M)08/3] were noted

NOTED

89. AREA CLINICAL FORUM MEETING MINUTES : 5 JUNE 2008

The Minutes of the Area Clinical Forum meeting held on 5 June 2008 [ACF(M)08/3] were noted.

NOTED

90. GLASGOW CENTRE FOR POPULATION HEALTH MEETING MINUTES : 9 JUNE 2008

The Minutes of the Glasgow Centre for Population Health meeting held on 9 June 2008 [GCPHMB(M)08/02] were noted.

NOTED

ACTION BY

91. AUDIT COMMITTEE MEETING MINUTES : 24 JUNE 2008

The Minutes of the Audit Committee meeting held on 24 June 2008 [A(M)08/04] were noted.

NOTED

92. PERFORMANCE REVIEW GROUP MEETING MINUTES : 1 JULY 2008

The Minutes of the Performance Review Group meeting held on 1 July 2008 [PRG(M)08/04] were noted.

NOTED

The meeting ended at 12.25 pm

NHSGG&C(M)08/6
Minutes: 93 - 95

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, 16 September 2008 at 11.15 am

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P R E S E N T

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE
Dr L de Caestecker
Mr R Cleland
Councillor J Coleman
Mrs A Coultard
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
Mr I Lee
Councillor D MacKay
Mrs J Murray
Mrs R K Nijjar
Councillor I Robertson
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
Mr J C Hamilton	..	Head of Board Administration
Mrs E Macfadyen	..	Secretariat Officer
Mr A McLaws	..	Director of Corporate Communications
Mr K Redpath	..	Director, West Dunbartonshire CHP
Mr I Reid	..	Director of Human Resources

ACTION BY

93. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Professor D Barlow, Mr G Carson, Dr D Colville, Ms R Crocket, Councillor J McIlwee, Mr G McLaughlin and Councillor A Stewart.

Mr Robertson welcomed Mr I Lee, Non-Executive Member, to his first NHS Board meeting.

94. FUTURE OF SERVICES AT VALE OF LEVEN HOSPITAL – PRE CONSULTATION DOCUMENT

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 08/41] asked the NHS Board to receive the pre-consultation document setting out the vision for the Vale of Leven Hospital and endorse a period of engagement on the vision of the Vale of Leven, from 17 September until the end of October 2008, followed by a period of formal consultation over 13 weeks from 31 October 2008 to the end of January 2009, with a formal report on the outcome to the February 2009 NHS Board meeting.

The NHS Board was also asked to note that issues raised during the engagement period would be addressed in the document that was circulated for formal consultation.

The Chair stressed the important role played by the Vale of Leven Hospital in the provision of health services to the West Dunbartonshire, Helensburgh and Lochside communities. However, for the last decade, the future of the hospital had been the subject of much debate and considerable concern following changes to services and transfer of services to other locations. He believed that the proposals being set out today showed that the Vale of Leven Hospital campus would continue to be a vibrant and busy NHS site that would have a continued role to play in the provision of NHS care to the local communities.

The Cabinet Secretary for Health and Well-Being had commissioned two independent reviews of unscheduled care at the Vale of Leven – the first was the Independent Scrutiny Panel, Chaired by Professor Angus Mackay, and the second was a group of expert clinicians, Chaired by Professor Chris Dodds. Both had concluded that anaesthetics was unsustainable at the Vale of Leven Hospital. Professor Mackay's review had recommended that an option be explored that anaesthetic services be sustained for two years to allow the further piloting of the prediction element of the Lomond Integrated Care model. The second review gave a definitive recommendation for how unscheduled services at the Vale of Leven could be delivered in the future and the Board's proposals took account of these recommendations in setting out a vision for the Vale of Leven which was hoped would end the uncertainty surrounding the hospital's future.

Mr Divers reminded Members that following the dissolution of NHS Argyll and Clyde, this NHS Board was asked to take responsibility for the services provided from the 'Clyde' area with effect from 1 April 2006. NHS Highland had taken responsibility for the remaining area of the former NHS Argyll and Clyde. Since April 2006 detailed work had been undertaken to review the health care services which were not already part of an agreed strategy. These reviews had included a comprehensive assessment of health need for the population of West Dunbartonshire. The current position was that the NHS Board had publicly consulted and approved recommendations for services to Older People, In-Patient Disability Services, Mental Health Services and the Community Midwifery Units at Inverclyde and the Vale of Leven. The NHS Board recommendations for the first three had been submitted to the Cabinet Secretary for approval, although for mental health services, further work was needed on the in-patient service north of the Clyde and this would be included in the pre-engagement document for the Vale of Leven Hospital. On the Community Midwifery Units, the NHS Board had concluded it would retain these for a further 3 years and launch a positive publicity campaign to encourage expectant mothers to consider using the units in future.

In addition, the NHS Board was required to implement a 3-year plan to reduce the recurrent financial deficit within the Clyde area of £26m: this work was well under way and due to be completed at the end of financial year 2009/10. An increasing proportion of cost savings delivered and attributed to Clyde will be as a result of integrating Greater Glasgow and Clyde services. Therefore savings released from Greater Glasgow service budgets as a direct result of that work would be attributed to Clyde. This follows the approach adopted in relation to establishing single services for financial services/payroll/internal audit and procurement.

Mr Divers advised that in addition to other deeply held concerns, two strong messages had come out of the public meetings he had attended on the Vale of Leven – firstly, the NHS Board should end this period of uncertainty and, secondly, there was a perception that NHS Board officials only ever came to speak to these local communities when services were being withdrawn as they could no longer be sustained. The proposals for the future of the Vale of Leven campus/…

were designed to give a vision for the future and end the uncertainty. The pre-engagement and consultation period thereafter could also discuss new and sustainable services that could be delivered at the hospital. By investing in the range of services that could be delivered on the Vale of Leven campus this would see an additional 16,000 appointments which are currently scheduled in Glasgow and Paisley being delivered locally. In addition, the vision included the development of a new Alexandria Medical Centre and a new Care Home on the Vale of Leven site delivered in partnership with West Dunbartonshire Council.

The Independent Review Report by the expert clinicians, Chaired by Professor Chris Dodds, was published on 15 August 2008 and provided conclusions and recommendations into the sustainability of anaesthetic services at the Vale of Leven Hospital. An important outcome of this review was the potential development of a model of care which would allow as many of the 6,000 patients who currently attended the Medical Assessment Unit as was clinically appropriate to continue to receive their care at the Vale of Leven. This model was described by the Review Team as being 'a supported GP Acute Unit'. These would be patients with medical conditions who had either been assessed by a GP as suitable for receiving care at the Vale of Leven or had presented at the hospital and had been deemed appropriate to treat. Initial work suggested that such a service could be developed which allowed 24-hour unscheduled care to be delivered by a team of doctors and nurse practitioners who were trained to provide GP services and skilled to deliver the required level of hospital care. The Review Team described the approach as one which "balances the need to provide care locally for as many patients as possible whilst delivering appropriate specialist care for those who needed it". It had been confirmed by both the Independent Reviews that the anaesthetic service was not sustainable: however, the proposal from Professor Dodds would enable the development of a model of care which would see a band of cases in the range of 36-83% being treated appropriately at a supported GP Acute Unit.

Mr Divers explained that the next 6 weeks of pre-engagement would allow time to firm up on the case-mix; develop a staffing model to support an experienced GP-led model; develop protocols for GP assessments and engage with staff, local groups and the public in order to shape the final proposals on the vision for the Vale of Leven Hospital for public consultation to commence on 31 October 2008. It had been agreed with the Scottish Health Council that a 6-week pre-engagement was reasonable on the basis of previous discussions with staff and the public on such matters affecting the Vale of Leven and it was planned to run the public consultation period from 31 October 2008 to 31 January 2009 with a full report on the outcome to go to the NHS Board meeting on Tuesday, 24 February 2009.

Ms Byrne took Members through the paper and presented in detail the services which it was proposed would form the vision for the Vale of Leven Hospital.

- **Unscheduled Care**

  The Vale of Leven Hospital would treat patients who had either been assessed by a GP as being suitable for treatment or who had presented at the hospital and were then assessed as being suitable for treatment.

  Weekly meetings were taking place with local GPs and Hospital Physicians to establish how many patients could safely be seen and identify the level of the physicians' support to the new model. Ms Byrne had also met with the wider community of GPs and this collaboration would continue. Two meetings with staff from the Vale of Leven Hospital had also taken place, with more meetings planned. Training had been identified as a significant issue for GPs and other clinical staff and this would require to be addressed.

- **Unscheduled Care: Transport**

  It was clear that some of the patients who currently attend the Medical Assessment Unit would need to transfer to the Royal Alexandra Hospital, Paisley for treatment. This would be in addition to the 5,000 patients from the Vale of Leven area who currently attended A&E at the Royal Alexandra Hospital, which included those patients who were most seriously ill. The Scottish Ambulance Service recognised the public's concern at the perceived risk associated with transferring patients but were confident from previous experiences that there were no additional risks in transferring this cohort of patients.

- **Unscheduled Care: Primary Percutaneous Coronary Intervention (PCI): Golden Jubilee National Hospital**

  A recent development had been the treatment of acutely unwell patients who suffer the most severe form of heart attack with Percutaneous Coronary Intervention as their primary treatment. The Scottish Ambulance Service, after an assessment of the patient, would take these patients directly to the Golden Jubilee National Hospital, Clydebank, in the same way as other patients in Glasgow and the West of Scotland.

- **Unscheduled Care: Treatment after Minor Injuries**

  There would be no change to the current service for the 9,000 unplanned patients who currently attended the Minor Injuries Unit.

- **Unscheduled Care: Primary Care Emergency Services**

  The out of hours primary care emergency services currently provided at the Vale of Leven Hospital would remain unchanged.

- **Planned Care**

  Most of the patients currently receiving care at the Vale of Leven Hospital, attended on a planned basis by way of an appointment.

  Ms Byrne explained that there were plans to enhance planned care services. In particular, there were plans for the expansion of Community, General and Secondary Dental Services, Surgical Services (Ophthalmology and Urology), General Medical Services (Rheumatology) and Regional Specialist Services (Renal Dialysis and Cancer Services).

- **Rehabilitation and Older People's Services**

  The provision of a comprehensive rehabilitation service was a key element of the NHS Board's vision for the Vale of Leven. It would be delivered by a Consultant-led multi-professional team and would include assessment, goal setting, intervention and evaluation. In addition to in-patients there would continue to be Consultant-led out-patient clinics for older people, stroke patients and those with movement disorders. There would be a Day Hospital for Older People; out-patient services for adults with a physical disability and the possible development of an enhanced community rehabilitation model in order to prevent older people being admitted to hospital. End-of-life care would also be part of the vision to be delivered from the Vale of Leven Hospital.

- **Adult Mental Health Services**

  Ms Byrne advised that between April and July 2008 a comprehensive formal public consultation on Modernising Mental Health Services in Clyde had taken place. The feedback from the consultation highlighted a low level of local public support for the proposal to transfer adult and elderly mental health acute admissions from the Vale of Leven Hospital to improved accommodation at Gartnavel Royal Hospital.

  As a result, the pre-engagement document included proposals for mental health services within the overall vision for the Vale of Leven Hospital. During the pre-engagement and consultation process, the advantages and disadvantages of both the integration of adult mental health services within the new facilities at Gartnavel Royal Hospital and of a local adult acute in-patient service at the Vale of Leven would be explored.

- **New Alexandria Medical Centre**

  Ms Byrne informed the NHS Board that plans were being developed for the provision of the new Alexandria Medical Centre. The Outline Business Case was due to be completed by the end of October 2008 and it was intended to provide a single purpose-built medical centre to accommodate a range of GP, Primary Care, Community Health and Social Care services for Alexandria. The preferred and available site was within the grounds of the Vale of Leven Hospital and planning permission had been granted for this facility on the preferred site.

- **New Care Home**

  The NHS Board was working with West Dunbartonshire Council on the development of a care home facility which could also provide continuing care for NHS patients. The Community Health Partnership was taking this proposal forward with the Council and locating it on the Vale of Leven Hospital site would allow for good synergies with both the hospital and primary care facilities.

- **Next Steps**

  Ms Byrne advised that meetings had been planned with the Community Health Partnership, HospitalWatch, Helensburgh and Lomond Planning Groups, and NHS Highland to set out the proposals for the Vale of Leven Hospital and receive feedback in order to shape and complete the consultation document to be launched on 31 October 2008. An invitation to West Dunbartonshire and Argyll and Bute Councils for meetings would also be offered.

  Eight Focus Groups for community-based groups had been arranged to establish what required to be addressed in the formal consultation document.

  When formal consultation had commenced, there were plans to hold consultation forums from late October 2008 through to end January 2009 and also public meetings to set out the NHS Board's proposals.

Mr Divers described his initial discussions with the Post-Graduate Dean and GP Postgraduate Adviser on the proposed GP Acute Unit at the Vale of Leven on how the medical staffing model could be developed and maintained.

The Chair thanked Mr Divers and Ms Byrne for their hard work in preparing an excellent report. He then invited questions from the NHS Board Members.

Cllr. Robertson was pleased with the vision and future which had been set out for the Vale of Leven Hospital and believed that a major corner had been turned and following the pre-engagement period he welcomed the prospect of the NHS Board consulting on proposals for this area which would be well received by the local communities. He recognised how important the GPs were to the model described for unscheduled care and the requirement to offer appropriate training in order to build up the skills and confidence of those referring into and delivering this new level of care

He was keen that structures were put in place to continue a dialogue with the communities beyond the implementation of the current proposals.

Mr Williamson welcomed the overall thrust of the vision for the Vale of Leven Hospital. He offered comments on improving aspects of the document, including making mention of the retention of the Community Midwifery Units at the Vale of Leven and Inverclyde Hospitals and enhancing the description of the cancer services to be offered from the Vale of Leven. He also raised the issue of GPs having a 3-tier on-call system – GP out-of-hours, the GP Acute Unit and providing support in relation to aspects of out-of-hours mental health services.

Mr Divers welcomed Cllr. Robertson's and Mr Williamson's comments and suggested that the West Dunbartonshire Community Health Partnership and the Council should work together on how to ensure continued engagement with local interests in a sustainable way going forward. Issues of out-of-hours care and GP training would be worked through with GPs and staff as the pre-engagement and consultation periods were under way. Mr Divers suggested that Ms Byrne work with Mr Williamson to progress discussions on cancer.

Director of Acute Services Strategy Implementation and Planning

Dr Kapasi expressed his satisfaction with the work described in the vision for the Vale of Leven and believed that there was a huge amount of excellence within the GP community which could be tapped into to provide the new service recommended by the Independent Review Team.

Mrs Stewart, in welcoming the proposals, was concerned about possible changes to the existing renal service and whether the new service could be adequately staffed. Mr Divers and Dr Cowan indicated that some services would require to be re-distributed and the discussions on the medical staff model for the GP Acute Unit would determine how it was best run and staffed.

Mr Sime hoped that the community and staff would welcome these proposals. Both Independent Review Reports had confirmed that the anaesthetic service was unsustainable and therefore it would be the case that some patients would not receive their care at the Vale of Leven. Mr Divers confirmed that some patients would indeed access the services of more specialised A&E care along with the 5,000 patients from this area who currently attended the Royal Alexandra Hospital. The task for Board officers was now to work through the case mix of which patients could be safely and sustainably treated at the Vale of Leven Hospital.

Mrs Smith welcomed the report and felt the local community would be encouraged with the proposals it contained. She did, however, have a concern that the 6-week pre-engagement period might not be long enough to conclude the detailed work required to complete the consultation document in sufficient detail for the community and staff to fully understand what was being proposed. She also raised a concern about the availability of the necessary capital investment required to deliver the vision for the Vale of Leven Hospital. Mr Divers advised that a significant element of work was already under way and he was chairing weekly/…

ACTION BY

meetings to ensure the various work streams came together in time for the start of the consultation period. In terms of the required capital investment required – the Alexandria Medical Centre had been planned and had been taken account of in the Board's current 3-year Capital Plan. The remaining elements would be included in a Capital Investment Plan for the Vale of Leven Hospital and the availability of capital funds would influence how best to achieve modern fit-for-purpose accommodation, whether by upgrading of existing facilities, a new-build programme or a combination of these approaches.

Mr Divers advised that some Non-Executive Members of the NHS Board had offered to be involved in the public consultation stage and he would arrange to contact those Members in order to ensure their involvement in the public meetings and meetings with the local communities.

The Chair thanked Members for their response to the proposals for the vision of the Vale of Leven Hospital and hoped the pre-engagement period would be used to fully inform the proposals to be launched in late October 2008 for public consultation.

DECIDED:

- That the attached pre-consultation document setting out the vision for the Vale of Leven Hospital be received.

- That a period of engagement on the vision of the Vale of Leven, from 17 September until the end of October 2008, followed by a period of formal consultation over 13 weeks from 31 October 2008 to the end of January 2009 and that the outcome be submitted to the NHS Board at its meeting on 24 February 2009, be endorsed. **Director of Acute Services Strategy Implementation & Planning**

- That issues raised during the engagement period would be addressed in the document that was circulated for formal consultation be noted. **Director of Acute Services Strategy Implementation & Planning**

95. PHARMACY PRACTICES COMMITTEE MEETING MINUTES: 4 AUGUST 2008; 6 AUGUST 2008; 12 AUGUST 2008; 13 AUGUST 2008; 20 AUGUST 2008; 22 AUGUST 2008; 25 AUGUST 2008

The Minutes of the Pharmacy Practices Committee meetings held on 4 August 2008 [PPC(M)08/11]; 6 August 2008 [PPC(M)08/12]; 12 August 2008 [PPC(M)08/13]; 13 August 2008 [PPC(M)08/14]; 20 August 2008 [PPC(M)08/15]; 22 August 2008 [PPC(M)08/16] and 25 August 2008 [PPC(M)08/17] were noted.

NOTED

The meeting ended at 12.55 p.m.

NHSGG&C(M)08/8
Minutes: 116 - 134

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, 16 December 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
Dr L de Caestecker
Mr R Cleland
Councillor J Coleman
Dr D Colville
Dr B Cowan (To Minute No 124)
Ms R Crocket
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
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
Mrs E Smith
Mrs A Stewart MBE
Councillor A Stewart
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
Dr E Crighton	..	Consultant in Public Health Medicine (for Minute No 126)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Ms S Laughlin	..	Head of Health Inequalities and Health Improvement (for Minute No 122)
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 125)

ACTION BY

116. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon, Professor D Barlow, Mrs A Coultard, Mr P Daniels OBE, Ms R Dhir MBE, Councillor J Handibode and Mr D Sime.

117. CHAIR'S REPORT

(i) Mr Robertson reported that NHS Board Chairs met with the Cabinet Secretary on 15 December 2008. At this meeting, two presentations were delivered on financial planning and Board effectiveness. The Cabinet Secretary advised that a report would shortly be issued on the draft Commonwealth Games Legacy Plan. One of the themes within this Plan would be "health" and the Board would be looking at this in detail to identify areas of benefits realisation in the lead up to (and after) the Games particularly in improving health and reducing health inequalities within NHS Greater Glasgow and Clyde.

ACTION BY

(ii) In progressing partnership working with neighbouring Universities, Mr Robertson met with representatives from Glasgow School of Art on 24 October 2008, the Principal and Executive Dean of the University of the West of Scotland on 13 November 2008 and attended a University/Board Strategy Group meeting on 8 December 2008. In addition, the British Heart Foundation had visited the University of Glasgow on 2 December 2008. Such continued dialogue heightened partnership working between further education establishments and NHS Greater Glasgow and Clyde and Mr Robertson commended work that was being taken forward jointly to improve the health of the population.

(iii) Mr Robertson continued to work closely with Local Authorities and had attended both North and South Lanarkshire's Health and Care Partnership meetings, a meeting arranged by the City Council Leader on CHCPs and Children and Family Services and had attended a meeting with the Leadership of Inverclyde Council.

NOTED

118. CHIEF EXECUTIVE'S UPDATE

(i) Significant effort had been made with progressing the Vale of Leven Hospital consultation exercise. Mr Divers, Ms Byrne and Mr Calderwood had attended meetings with West Dunbartonshire Council and Argyll and Bute Council as well as four public meetings. A final round of public meetings would be held in January 2009.

(ii) On 7 November 2008, Mr Divers and the Chairman had attended the unveiling of a plaque at Glasgow Royal Infirmary to commemorate Professor Tom Gibson who had been a pioneer of plastic surgery and bioengineering and had died in 1993. As a co-founder of the Bioengineering Unit at the University of Strathclyde (a department oriented to apply the principles and techniques of engineering to surgery and medicine), the Unit, under his inspired guidance, grew into the international centre of excellence that it was today.

NOTED

119. MINUTES

On the motion of Mrs A Stewart, seconded by Mr P Hamilton, the Minutes of the meeting of the NHS Board held on Tuesday, 21 October 2008 [NHSGG&C(M)08/7] were approved as an accurate record and signed by the Chair.

NOTED

120. MATTERS ARISING FROM THE MINUTES

(i) The rolling action list of Matters Arising was circulated and noted. Mr Divers highlighted two points:

- An audit of mortuary and viewing areas in hospitals within NHS Greater Glasgow and Clyde had been carried out and the outcome reported to Members in a letter dated 11 December 2008.

ACTION BY

- The outstanding work relating to progressing two alternative options with St Margaret's Hospice (namely nursing home care or services for the elderly mentally ill) had not progressed and efforts continued to be made to engage with the Hospice around the two options which might contribute to the NHS Board's declared strategy.

(ii) Mr Divers confirmed that there would be a further meeting with Sir John Savill, the new Chief Scientist for NHS Scotland, on Friday 19 December 2008. At this meeting, he would be discussing the priorities for research in Scotland, how finance could be directed to the four clinical academic centres and how future collaboration could be taken forward. This matter would also form part of the NHS Board Seminar in February 2009 and Sir John and his colleagues would be in attendance.

NOTED

121. NHS GREATER GLASGOW AND CLYDE – OUTCOME OF HER MAJESTY'S INSPECTORATE OF EDUCATION (HMIe) REVIEWS

A report of the Board Nurse Director [Board Paper No 08/53] asked Members to note a summary of the HMIe service reports to protect children, recognising that inspections were multi-agency.

Ms Crocket summarised the HMIe inspection reports specific to East Renfrewshire, Renfrewshire and South Lanarkshire, confirming that reports had yet to be received for Inverclyde and Glasgow City.

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 of Administration (SCRA), 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 that worked to protect children living in the area. Some of the children and families in the sample met and talked to inspectors about the services they had received.

Inspectors visited services that provided help to children and families and met users of these services. They talked to staff with responsibilities for protecting children across all the key services – this included staff with leadership and operational management responsibilities as well as those working directly with children and families. Inspectors also sampled work that was being undertaken in the area to protect children by attending meetings and reviews.

Ms Crocket summarised the lessons learned and noted that these were progressed through a comprehensive range of governance structures. She highlighted areas of strength that had been reported and confirmed that, overall, the inspectors' reports concluded that they were either confident (or very confident) that children who required protection were known to services and prompt action was taken to ensure their safety. Children and their families were well supported by staff. That said, there was always room for further improvement, therefore, each Child Protection Group had developed an action plan specific to their report indicators on how they would address the main recommendations in their report. This would enable the Inspectorate, when they revisited, to assess and measure the progress.

ACTION BY

Mr Williamson asked what evidence existed to show children safer and risks being better measured. Ms Crocket responded by confirming that better assessment tools were used to support the multi-agency assessment of children. As a result of this, risks could be better identified, vulnerability assessed and a more comprehensive approach used to tackle this. All risk registers were constantly monitored and the HMIe visits included a detailed analysis of case conferences. Given enhanced integrated care services, there was, however, an urgent need for increased e-care developments which would support this interaction and give it a sharper focus.

Councillor MacKay was heartened by the good progress and proactive approach to child protection. He recognised that this was the beginning of the process and the real test would be in ensuring that mechanisms continued to be fit for purpose. Councillor Robertson confirmed that the HMIe follow-through inspection reported on work undertaken to achieve any weaknesses they may have identified in their earlier report.

In terms of some of the quality indicators being scaled as "satisfactory", Mr McLaughlin asked what measures would be put in place to ensure these were evaluated, in the future, as "good" or "very good". Ms Crocket confirmed that "satisfactory" meant that strengths just outweighed weaknesses and agreed it would be helpful that the next monitoring report identify how areas of risk were identified and what actions were being taken locally to improve performance prior to follow-through inspections. **Nurse Director**

NOTED

122. EQUALITY LEGISLATION – SECOND MONITORING REPORT FOR THE NHS GREATER GLASGOW AND CLYDE EQUALITY SCHEME 2006-2009

A report of the Head of Inequalities and Health Improvement [Board Paper No 08/54] asked the Board to review and discuss progress in implementing the NHSGGC Equality Scheme 2006 to 2009; note the specific improvements that would be made over 2009 and approve the second monitoring report.

Ms Laughlin explained that a single Equality Scheme and Strategic Action Plan had been produced for NHSGGC in order to harmonise the requirements of current Equality legislation. Public sector organisations had a requirement to produce an annual monitoring report and the NHS Board's second monitoring report had been produced to build on the first report which was endorsed at the NHS Board meeting in December 2007.

Ms Laughlin led the NHS Board through the monitoring report summarising the extent of progress over the last year and identifying where further progress still needed to be made. The second monitoring report had been produced with a number of different audiences in mind, both internal and external, and included the Equality and Human Rights Commission which had a mandate to ensure that equality law was adhered to.

The overall conclusion of the report was that the response by the NHS Board to the legislation in the second year, following the Equality Scheme, was proportionate and relevant to the size and nature of the organisation and that there had been incremental progress since year one. The report did, however, reiterate the need to meet the challenge of implementing equalities legislation across an organisation of the complexity of NHSGGC and its substantial workforce. As such, Ms Laughlin identified areas where activity would be focussed for 2009.

ACTION BY

In response to a question from Mrs Stewart, Ms Laughlin confirmed that work being conducted within CH(C)Ps was unified in that Local Authorities also had a single scheme. It was not the case, therefore, that there were two sets of expectations. It was, however, recognised that integration varied throughout the CH(C)Ps and Ms Laughlin confirmed that this area would be picked up in 2009.

Mr Carson referred to the NHS Board's commitment to Equality Impact Assessments (EQIA). He noted that a database had been developed which captured progress of EQIAs across NHSGGC and this was updated on a six-weekly basis. Furthermore, a quality assurance tool was being developed and, once this was applied, approved completed EQIAs would be posted on the NHSGGC Equality In Health Website. At the moment, the various tools and fact sheets were available on this site. Mr Carson wondered whether it was possible to capture how many hits this site had received in an attempt to measure usage. Ms Laughlin confirmed that, at the moment, it was not possible to capture this but by next year it would be. She confirmed, however, that it was her understanding the site was largely used by those areas that members of the Corporate Inequalities Team were working with.

With regard to the development of the workforce and work place, Mr Carson was disappointed to note that only 0.36% disclosed a disability. Ms Laughlin, in acknowledging that progress needed to be made, emphasised that staff needed to be willing to provide the information. Although the figure did appear low, this may not, in fact, reflect the total number of those with a disability in the workforce.

Councillor Yates commended the good progress made to date and recognised that this would be incremental and that progress was moving in the right direction. Mr Lee agreed and re-emphasised the importance of embedding this work in the organisation.

DECIDED:

(i)	That progress in implementing the NHS Greater Glasgow and Clyde Equality Scheme 2006-2009 be reviewed and discussed.	**Head of Inequalities and Health Improvement**
(ii)	That the specific improvement to be made over 2009 be noted.	**Head of Inequalities and Health Improvement**
(iii)	That second monitoring report be approved.	**Head of Inequalities and Health Improvement**

123. PROGRESS REPORT ON C.DIFF ACTION PLAN

A report of the Board Medical Director [Board Paper No 08/55] asked the NHS Board to receive a further update to the NHSGGC C.Diff Action Plan.

Dr Cowan confirmed that the first progress report had been submitted to the Performance Review Group on 16 September 2008. A further update and outline of the progress report provided to the Scottish Government Health Directorate on 1 November 2008 was submitted to the Performance Review Group on 18 November 2008.

Dr Cowan led the NHS Board through the specific actions and provided the completion/target date as well as the current status for each. He reported that the Infection Team, chaired by Professor Cairns Smith, was due to revisit the Vale of Leven Hospital on 23 December 2008.

ACTION BY

To date, the format and structure of that meeting had not been confirmed but it was expected that Professor Cairns Smith would look for evidence of improvements in processes and procedures and would seek to gather this from frontline clinical staff.

In response to a question from Mrs Murray, Dr Cowan explained the revised infection control team structure. He was confident that the new structure was much clearer in terms of ownership and responsibility, emphasising that everyone knew their role in meeting policy guidelines with regard to control of infection. He confirmed that this was now high on all staff agendas with it being regularly discussed at directorate meetings and Performance Reviews. Over and above this, Key Performance Indicators (KPIs) for infection control had been applied to all levels from the ward to the Board based on the forthcoming national monitoring template. Mrs Nijjar welcomed this restructuring and thanked Dr Cowan and his team for providing reassurance that the NHS Board was responding positively in this area of great concern.

Dr Benton asked if figures of incidences could be made available for each hospital within the NHS Board's area. Dr Cowan confirmed that information was regularly produced by Health Protection Scotland (HPS) and this would be provided to the NHS Board as part of the Healthcare Acquired Infection bi-monthly report to be introduced in the New Year. **Medical Director**

Mr P Hamilton asked about the police investigation taking place. Mr Divers confirmed that the police team involved had now received the case notes for the Vale of Leven patients affected and were aware of the complexity of the evidence involved. In terms of preparing staff for the investigation, The Central Legal Office (CLO) had been engaged in providing staff with advice as had the Royal College of Nursing (RCN). Counselling services had also been made available to staff in anticipation of the police investigation.

Councillor Robertson registered his support of all the action being taken particularly with regard to assisting staff.

This further progress report had been provided to the Scottish Government Health Directorate on 15 December 2008.

NOTED

124. 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 08/56] asked the NHS Board to note progress in moving forward the development of CHCPs and in developing the approach to the review of joint working with Glasgow City Council.

Ms Renfrew outlined the arrangements which provided a platform to achieve positive progress with Glasgow City Council in relation to CHCPs and a clear framework to move forward the review of joint working. The NHS Board Chair and Glasgow City Council Leader had agreed that their respective Chief Executives would work together to develop and bring forward proposals to address the issues which were impeding delivery of the two organisations' clearly articulated and shared vision. It was hoped this would be achieved by the end of January 2009. A series of discussions with CHCP Directors and management teams had, so far, enabled the development of an initial agenda which would now form part of the joint process with the Council. Ms Renfrew summarised these issues, which lay in four key challenge areas as follows:

ACTION BY

- Finance
- Service integration and improvement
- Governance
- Human resources

NOTED:

125. 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 08/57] 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 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**

126. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT TO MARCH 2008

A report of the Director of Public Health [Board Paper No 08/58] asked Members to note the Public Health Screening Programmes Annual Report to March 2008.

Dr de Caestecker introduced Dr Crighton, Consultant in Public Health Medicine, to present this report. Dr Crighton reported 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 service conditions. The annual report presented information about the following screening programmes offered to residents across NHSGGC for the period 2007/08:

- Cervical screening
- Breast screening
- Communicable diseases in pregnancy
- Down's syndrome and other congenital anomalies
- Newborn bloodspot
- Universal newborn hearing
- Diabetic retinopathy screening
- Pre-school vision screening

Dr Crighton reported that, in addition, the report also highlighted plans for:

- Bowel screening
- The replacement of the existing Pregnancy Screening Programme offered for Down's syndrome and other congenital anomalies.
- Haemoglobinopathy screening both during pregnancy and for new born babies.
- The extension of the newborn bloodspot screening programme to include screening for Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD).

ACTION BY

Dr Crighton confirmed that, each year, approximately 250,000 NHSGGC residents were eligible for screening. As part of the NHS Board's commitment to tackling inequalities in health, the Public Health Screening Unit engaged with voluntary and statutory services to identify effective ways to encourage and promote uptake of screening programmes.

Dr Crighton led the NHS Board through a summary of each of the above-named screening programmes confirming that they stretched across the whole organisation and their successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment.

As such, 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.

In response to Dr Colville, Dr Crighton confirmed that laboratories and researchers were prepared for the increased samples they would receive from 31 March 2009 when the new bowel screening programme would commence.

Mr Lee referred to the disappointing uptake rate of pre-school visual screening in East Glasgow compared to the West. He was advised that there had been a shortage of staff in the area which had prevented the delivery of screening in nurseries. Resources were now being redirected to East Glasgow to remedy this situation.

Mr Williamson commended the programmes and paid tribute to all staff involved in their delivery. Mr Divers confirmed for Mr Williamson that there was capacity to offer all patients with diabetes diabetic retinopathy screening.

Dr Benton thought it would be useful to see a breakdown of the breast cancer screening statistics by CH(C)Ps. Dr Crighton confirmed that this could be made available. **Director of Public Health**

In response to Mr Cleland, Dr Crighton reported that data was not analysed by ethnicity, therefore, it was not possible to analyse the uptake of screening programmes by ethnic minorities. In order to do this, improvements had to be made to the technology but, even with this technical issue resolved, the data could only be captured if individuals were prepared to divulge it. Dr Colville believed that GP practices were improving such recording and suggested this may help Dr Crighton. **Director of Public Health**

NOTED

127. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No 08/59] asked the NHS Board to note progress against the national targets as at the end of October 2008.

Mr Calderwood reported that the target set by the Scottish Government was that by March 2011, the total maximum journey time for patients would be eighteen weeks from referral to treatment. The Government had set an interim milestone for March 2009 when the maximum wait for an outpatient appointment would be fifteen weeks and the maximum wait for admissions for inpatient and day case treatment would also be fifteen weeks. As at the end of September 2008, all inpatients, day cases and outpatients had been given an appointment within fifteen weeks, ensuring that the NHS Board had achieved this target six months early.

ACTION BY

Mr Calderwood outlined how the Acute Division was now working towards delivery of the twelve week waiting time target for outpatients, inpatients/day cases.

As a milestone towards achieving the eighteen week referral to treatment standard, the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy would be six weeks by the end of March 2009. Mr Calderwood confirmed that the Acute Division continued to make progress towards achieving this six week target.

The NHS Board discussed the delayed discharge statistics and noted that since the April 2008 target had been achieved, performance had fallen back. Mr Calderwood reported that discharge of four of the patients in Renfrewshire and South Lanarkshire had been delayed because of funding issues. Other patients were delayed, awaiting particular placements or for housing issues to be resolved. This situation was clearly of concern to the NHS Board and it was accepted that there needed to be a clear way forward to meet the target and that this may involve designing solutions that were not necessarily resource related. On this point, Mr Carson referred to the role of voluntary organisations who could provide support and advice. There were also independent living allowances and packages and some voluntary agencies would help with the arrangements around these. Mr Divers agreed that each delayed discharge should be tracked on a case by case basis to see budgetary movements. He also welcomed Mr Carson's comments and agreed to explore this further. **Chief Operating Officer**

NOTED

128. FINANCIAL MONITORING REPORT FOR THE 6 MONTH PERIOD TO 30 SEPTEMBER 2008

A report of the Director of Finance [Board Paper No 08/60] noted the NHS Board's financial performance for the first six months of the financial year.

Mr Griffin reported that the NHS Board and its Operational Divisions were currently reporting a close to breakeven position against its revenue budget after the first six months of the year. The NHS Board continued to forecast a revenue breakeven position for 2008/09.

Mr Griffin detailed expenditure to date against the NHS Board's 2008/09 capital allocation and highlighted progress on achievement of the NHS Board's 2008/09 cost savings targets. He commented on the financial outlook for 2009/10 and set out the extent of the savings targets that would be required to deliver a balanced financial plan.

NOTED

129. QUARTERLY REPORT ON COMPLAINTS : 1 JULY – 30 SEPTEMBER 2008

A report of the Head of Board Administration, Chief Operating Officer – Acute and Lead Director (CHCP), Glasgow [Board Paper No 08/61] asked the NHS Board to note the quarterly report on NHS complaints in Greater Glasgow and Clyde for the period 1 July to 30 September 2008.

ACTION BY

Mr Hamilton confirmed that he had written to all Directors asking that there be an increased focus on the handling of complaints in order to bring about an improvement in their performance of responding to at least 70% of complaints within 20 working days. The CH(C)P Committees, Mental Health Partnership Committee and Senior Management Team for the Acute Service Division had been asked to review regular reports on the handling of NHS complaints to ensure a more local focus. Future Organisational Performance Review Group meetings would also include reviewing the performance in handling complaints against the national target.

Mr Hamilton recorded that this quarter's complaints report showed an 8% improvement in performance and the Acute Services Division's likely figure for October 2008 would be near 68%.

Mr Carson welcomed the improvement in the response rates and noted that, set in context, Members should recognise the volume of patient activity undertaken across NHS Greater Glasgow and Clyde.

In response to a question from Mrs Stewart, Mr Hamilton confirmed that the NHS Board wrote and confirmed the steps taken to implement the Ombudsman's actions/recommendations and any other action taken as a result of their report. In each case, it was also necessary to notify the Chief Executive, NHS Scotland, of the actions taken in connection with their possible attendance at the Scottish Parliament Health Committee. Furthermore, each recommendation made by the Ombudsman was submitted to the Clinical Governance Committee with an action plan showing appropriate action against each item. The Clinical Governance Committee had the responsibility, on behalf of the NHS Board, to ensure that each recommendation was implemented in the interests of effective and safe care delivered to the population served.

NOTED

130. CLINICAL GOVERNANCE COMMITTEE MINUTES : 5 AUGUST 2008 AND 8 OCTOBER 2008

The Minutes of the Clinical Governance Committee meetings held on 5 August 2008 [CGC(M)08/4] and 8 October 2008 [CGC(M)08/5] were noted.

NOTED

131. INVOLVING PEOPLE COMMITTEE MINUTES : 6 OCTOBER 2008

The Minutes of the Involving People Committee meeting held on 6 October 2008 [IPC(M)08/05] were noted.

NOTED

132. PHARMACY PRACTICES COMMITTEE MINUTES : 27 OCTOBER 2008, 3 NOVEMBER 2008, 10 NOVEMBER 2008 AND 21 NOVEMBER 2008

The Minutes of the Pharmacy Practices Committee meetings held on 27 October 2008 [PPC(M)08/20], 3 November 2008 [PPC(M)08/21], 10 November 2008 [PPC(M)08/22] and 21 November 2008 [PPC(M)08/23] were noted.

NOTED

ACTION BY

133. RESEARCH ETHICS GOVERNANCE COMMITTEE MINUTES : 17 NOVEMBER 2008

The Minutes of the Research Ethics Governance Committee meeting held on 17 November 2008 [REGC(M)08/3] were noted.

NOTED

134. PERFORMANCE REVIEW GROUP MINUTES: 18 NOVEMBER 2008

The Minutes of the Performance Review Group meeting held on 18 November 2008 [PRG(M)08/06] were noted.

NOTED

The meeting ended at 12.20 pm

NHSGG&C(M)15/07
Minutes: 100 - 122

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 December 2015 at 9:30a.m.

PRESENT

Mr J Brown CBE (in the Chair)

Dr J Armstrong	Councillor M Kerr
Mrs S Brimelow OBE	Councillor A Lafferty
Ms M Brown	Mr I Lee
Mr R Calderwood	Dr D Lyons
Dr H Cameron	Dr M McGuire
Mr S Carr	Mr A Macleod
Councillor G Casey	Councillor M Macmillan
Professor A Dominiczak OBE	Ms R Micklem
Mr R Finnie	Dr R Reid
Mr I Fraser	Rev Dr N Shanks

Mr M White

IN ATTENDANCE

Mr G Archibald	Chief Officer, Acute Services Division
Ms R Campbell	Health Improvement Lead (Tobacco) [For Minute 109]
Dr E Crighton	Interim Director of Public Health
Mr A Curran	Head of Capital Planning & Procurement [For Minute 112]
Ms J Erdman	Head of Inequalities [For Minute 110]
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Mr D Loudon	Director of Facilities & Capital Planning
Mr A McLaws	Director of Corporate Communications
Mrs A MacPherson	Director of Human Resources & Organisational Development
Ms P Mullen	Head of Performance
Mrs K Murray	Director, East Dunbartonshire HSCP
Ms C Renfrew	Director of Planning & Policy
Professor C Williams	Consultant Microbiologist [For Minute 107]

ACTION BY

100. WELCOME AND APOLOGIES

Presiding over his first NHS Board meeting as Chairman, Mr Brown reported that there would be a number of new Non-Executive Board Member positions advertised early in the new year. To ensure wide ranging and diverse interest in these opportunities, a proactive marketing campaign would be launched detailing the work, influence and rewards of being a Non-Executive Director of Scotland's largest health board.

Apologies for absence were intimated on behalf of Councillor M Devlin, Mrs T MacAuley OBE, Councillor J McIlwee, Councillor M O'Donnell and Mr D Sime.

NOTED

101. DECLARATION(S) OF INTEREST(S)

Declaration of Interest – Dr D Lyons:-

- Agenda Item No 11 - "Equality Counts: Using Data to Understand and Tackle Inequality in NHSGGC".

Member of Scotland Committee of the Equality and Human Rights Commission.

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

NOTED

102. CHAIR'S REPORT

Mr J Brown reported that he had had a very busy, informative and enjoyable first two weeks in his role as NHS Board Chair. He summarised his one-to-one meetings with individuals, attendance at meetings and visits to meet frontline staff and services including the following:-

- Various one-to-one meetings with Executive Directors, Senior Staff and, in particular, the NHS Board's Chief Executive.

- Various Committee meetings including the NHS Boards Chairs meeting with the Cabinet Secretary for Health, Wellbeing and Sport on 30 November 2015, the NHS Board Seminar on 1 December 2015, the Area Clinical Forum meeting on 3 December 2015, the Staff Governance Committee meeting on 8 December 2015 and a meeting of Glasgow Centre for Population Health Board on 11 December 2015.

- Meetings with frontline staff at the Neuro Institute, Queen Elizabeth University Hospital (Accident & Emergency (A&E) department, Immediate Assessment Unit (IAU) and Clinical Decision Unit (CDU)), Royal Hospital for Children and Glasgow Royal Infirmary (A&E, IAU, CDU and Acute Receiving departments).

Mr Brown had also met with the Cabinet Secretary for Health, Wellbeing and Sport and the Chief Executive of NHS Scotland to provide them with an update on the following within NHSGGC:-

- Winter planning/unscheduled care;
- Langlands Unit and Care for Older People;
- Relationship with Health Improvement Scotland (HIS) and, in particular, its latest report on the Langlands Unit;
- Infection Control and the NHS Board's relationship with Health Protection Scotland.

He was encouraged that the Cabinet Secretary had agreed to continue with his one-to-one meetings and also to meet with NHS Board Members at a time to be agreed in 2016.

In terms of Mr Brown's representational duties, he had attended the following:-

- A dedication ceremony for the sanctuary at the Queen Elizabeth University Hospital.
- The CLIC Sargent Hospitals' Christmas Carol Concert.
- The 100 years celebration event at Glasgow Royal Infirmary.

NOTED

103. CHIEF EXECUTIVE'S UPDATE

(i) On 26 October 2015, Mr Calderwood attended a cutting of the sod of the ICE Building at the Queen Elizabeth University Hospital. This was conducted by Mr J Johnson, UK Minister for Science and Universities and Professor A Dominiczak was also in attendance. This represented the cementing of the relationship between the NHS Board and the University of Glasgow on the Queen Elizabeth University Hospital campus.

(ii) On 4 November 2015, Mr Calderwood attended the Scottish Health Awards ceremony where four members of staff, across the organisation, picked up awards. He took the opportunity to congratulate them and paid tribute to the positive evening.

(iii) On 20 November 2015, Mr Calderwood and Mr Archibald met with the Cabinet Secretary for Health, Wellbeing and Sport to discuss the NHS Board's Winter Planning arrangements.

(iv) On 23 November 2015, Mr Calderwood attended an evening reception at the Queen Elizabeth Teaching & Learning Centre for NHSGGC's reservist staff. This was an excellent informal evening, recognising the contribution of the reservist forces. The event recognised that the regular training undertaken by the reserve forces enhanced and developed the skills and knowledge of NHSGGC's employees and that it was of long-term benefit to the organisation.

(v) On 30 November 2015, Mr Calderwood met with Duncan McNeil MSP to discuss a wide range of issues, particularly around the future of NHS services in Inverclyde.

NOTED

104. MINUTES

On the motion of Professor A Dominiczak, seconded by Rev Dr N Shanks, the minutes of the NHS Board meeting held on Tuesday, 20 October 2015 [NHSGGC(M)15/06] were approved as an accurate record and signed by the Chair.

NOTED

105. MATTERS ARISING FROM THE MINUTES

The Rolling Action List of matters arising was noted.

NOTED

106. SCOTTISH PATIENT SAFETY PROGRAMME MATERNITY UPDATE

A report of the NHS Board's Nurse Director [Board Paper No 15/60] asked the NHS Board to note the progress reported from the Women's & Children's Directorate in implementation of the SPSP workstream for Paediatric, Maternal and Neonatal care.

Dr McGuire explained that the specific aim for this workstream 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 18 teams supported across Paediatric and Neonatal services. Initially, following the move to the Royal Hospital for Children, it was considered prudent to continue with monthly data submissions even for those teams which had made good progress and were showing a reliable process had been embedded. A number of these teams had now shown sustained reliability through the move and could be stepped down to reduce levels of process measurement.

Dr McGuire led the NHS Board through a summary of the workstreams including Peri-op, critical care, PICU and neonate workstreams.

In terms of next steps, the Directorate had undertaken a review of current measures and mapped these against the clinical priorities. It had been agreed that the MCQIC work would concentrate on five areas as follows:-

- Women's satisfaction with their care;
- Smoking in pregnancy;
- Foetal heart rate monitoring;
- Post-partum haemorrhage;
- Significant events debrief.

In response to a question from Mr Lee regarding the clinical choice in using elastoplast to secure the PVC device instead of the recommended sterile PVC dressing, Professor Williams explained that, although this presented no infection risk, work continued with clinicians to ensure compliance with national standards. He understood, however, that the adhesiveness on an elastoplast was greater and, therefore, it stayed on longer which made it preferable for some clinicians.

Ms Micklem asked about outcome measures and when these would be available. Dr McGuire explained that, firstly, data had to be gathered in order to measure outcomes and identify benefits. Currently, the NHS Board was at the information gathering and data collecting stage for these workstreams. That way, baselines would be established before a move to identify improvements could be made.

Members agreed that the various graphs and tables could be difficult to decipher and understand. Dr McGuire explained that the format was set nationally but that she would refine the information to make it easier to understand in terms of local NHSGGC performance. It was suggested that future reports include a summary but highlight exception reporting. Dr McGuire agreed to work with Dr Armstrong and Mrs Brimelow to identify how the NHS Board could be provided with a more distilled version than the one provided to the Scottish Government. Dr McGuire agreed to provide the different report from February 2016 onwards in an attempt to make the

Nurse Director

text, graphs and tables easier to understand and add a glossary of terms, recognising that a fuller set of information was required to comply with the SGHD template.

NOTED

107. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 15/61] 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

Referring to the earlier discussion on SPSP, Dr Armstrong explained that the format of this report was similarly prescribed by the SGHD but she would attempt to simplify it and provide an executive summary for future NHS Board meetings. **Medical Director**

Dr Armstrong led the NHS Board through the actions being taken to address the disappointing increase in SABs for the April to June 2015 quarter. She explained that over half of the 116 SAB cases in NHSGGC during quarter 2 were hospital acquired. 26 patients had the source of their SAB identified as an intravenous access device (CVC or PVC). Eleven patients had no clear source identified for source of sepsis following thorough investigation by the Infection Prevention and Control Team and the local clinical team.

In looking at the outbreaks/exception reporting, Dr Armstrong summarised the situation which saw an increased incidence of serratia marascens in patients in the Neonatal Intensive Care Unit (NICU) at the Royal Hospital for Children. She explained that an action plan had been developed and agreed between Health Protection Scotland and NHSGGC. Progress against the plan was reported at each Incident Management Team meeting and Dr Armstrong summarised the actions being taken to date to address this.

In response to a question from the Chairman, Dr Armstrong clarified that, sadly, a very premature baby with complex medical problems died with serratia marascens present in the bloodstream.

In response to a question from Mr Finnie regarding the source of SABs being identified as a CVC or PVC, Dr Armstrong explained that, when doing improvement programmes, all efforts were made to embed the principles in wards and change local practice. Given the moves to the new Queen Elizabeth University Hospital, new staff were working in new wards and she acknowledged the need to revisit and further embed compliance with the Standard Operating Procedure for the insertion, care and maintenance of CVCs and PVCs. In response to a further question, she explained that this did indeed include how and when they were being used, their insertion and their

removal. This information was monitored via the Infection Prevention & Control Audit, the results of which were returned to the Chief Nurses for the area and included in the Sector monthly reports. That way, spikes were easily identifiable and resultant action initiated. Professor Williams added that a two part approach was being taken in that ward audits of IV access devices were undertaken and that a more detailed piece of work was being established to look at local barriers where compliance was not being sustained in an attempt to identify methods of improvement.

NOTED

108. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT: 1 APRIL 2014 TO 31 MARCH 2015

A report of the Interim Director of Public Health [Board Paper No 15/62] asked the NHS Board to note the "Public Health Screening Programmes Annual Report from 1 April 2014 to 31 March 2015".

Dr Crighton presented information about the following screening programmes offered to residents across NHSGGC for the period 2014/15:-

- Cervical screening
- Breast screening
- Bowel screening
- Pregnancy screening:-
  - Communicable diseases in pregnancy
  - Haemoglobin apothics in screening
  - Downs syndrome and other congenital anomalies
- Newborn 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.

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 clarifying the following:-

- Efforts were made to engage with communities where there was low uptake in the screening programmes. Given that previous evidence suggested that attitudes and health behaviours were different in some communities, every effort was made to address their needs – these efforts would continue in deprived areas to address the shortfall in uptake.

- Although huge improvements had been made in the pre-school vision screening programme compared to previous years, a lot of work continued, not only in meeting with local nurseries but in making contact with those children not registered with a nursery.

- A priority was to engage with the hard-to-reach communities. Although this continued to be a challenge it would be a priority to ensure that the inequalities gap did not widen. However, it was also important to celebrate success and what had been achieved so far in the uptake of the screening programmes. The lack of uptake in some areas should not influence the areas where the screening programmes did well.

- Screening programmes were national programmes and any intent to extend would be a national decision.

- Agreement that the report should be considered locally by IJBs to analyse performance within localities in more detail.

- Work was being undertaken nationally to look at interval cancers and compare these nationally/internationally to undertake some benchmarking with a view to looking at the merits of extending the programmes, in particular, breast screening.

NOTED

109. PROPOSED AMENDMENT TO NHSGGC SMOKEFREE POLICY

A report of the Interim Director of Public Health [Board Paper No 15/63] asked the NHS Board to note the report and support implementation of two recommendations (firstly, to amend the current Smokefree Policy to allow the use of e-cigarettes in designated areas within NHSGGC's grounds and, secondly, to establish a Board-wide process to develop a shared criteria for identifying suitable arrangements allowing the use of e-cigarettes on NHSGGC's grounds).

Dr Crighton explained that NHSGGC's current Smokefree Policy (2014) prohibited smoking on all NHSGGC sites including all buildings, vehicles and grounds. It also currently included e-cigarettes and smokeless cigarettes. The policy stated that the position around e-cigarettes would be reviewed in accordance with emerging evidence around the potential role that they could contribute towards tobacco control.

Dr Crighton alluded to the emergence of new evidence that showed e-cigarettes to be an effective tool in tackling harmful tobacco smoking rates and that their controlled use would further support the drive to try and make all NHSGGC sites completely tobacco-free in line with the national policy. Based on this new evidence, a review of the NHS Board's Smokefree Policy position on e-cigarettes was timely and would improve consistency between the use of e-cigarettes within NHS grounds and the "e-cig friendly" approach being recommended for cessation services.

In response to a question, Ms Campbell outlined that the Scottish Government's position on e-cigarettes was more positive than negative with a recently proposed Bill focusing on restricting e-cigarettes advertising and sales to under 18s but not imposing stronger restrictions on location of use.

Currently, only NHS Lothian allowed e-cigarette use in designated areas although a number of other NHS Boards were now reviewing this situation in light of the evidence that had been published recently. Dr Crighton was clear that the NHS was not promoting the use of e-cigarettes but seeing their potential as a way to reduce the mortality and morbidity caused by combustible tobacco.

Given the evidence available, the NHS Board was supportive of the change to its policy with the following suggestions around how this could be managed locally:-

- Specific areas within NHSGGC's grounds where e-cigarettes would be permitted would be identified. The policy change did not mean that e-cigarettes could be used anywhere on the NHS Board's grounds, but in designated areas only.

- A communications plan for patients, staff and visitors would be developed to make clear that tobacco and e-cigarettes were treated differently and advise where people could use e-cigarettes on the NHS Board's grounds.

DECIDED

- That, the report be noted.

- That, the current Smokefree Policy be amended to allow the use of e-cigarettes in designated areas within NHGGC's grounds. **Interim Director of Public Health**

- That, a Board-wide process to develop a shared criteria for identifying suitable arrangements allowing the use of e-cigarettes on NHSGGC's grounds be established. **" "**

110. EQUALITY COUNTS: USING DATA TO UNDERSTAND AND TACKLE INEQUALITY IN NHSGGC

A report of the Director of Planning & Policy [Board Paper No 15/64] asked the NHS Board to receive the update on using data to understand and tackle inequality in NHSGGC and support the six recommendations for action.

Ms Erdman explained that tackling inequality was one of NHSGGC's five priorities. Patterns of inequality were evident in the way NHSGGC's population made use of health services. Historically, health and social care services had largely been planned without taking into account patients' needs in relation to inequality and discrimination. Sometimes this had been because everyone in the target group was considered excluded or vulnerable or simply because the data was not available to identify the needs of groups within groups. In order to understand the population and develop better services, the NHS Board needed to collect and use a wide range of evidence to help build up a more complete picture. Data on patients' use of services and health outcomes by protected characteristics, patient/client feedback by equality groups, and equality impact assessments could be used to build that picture.

She explained that collecting data by protected characteristics was part of the requirements of the equality legislation, and ideally, the NHS Board should ask and record patients' ethnicity, sex, disability, age, sexual orientation and religion/belief. The Scottish Index of Multiple Deprivation (SIMD), based on postcode, was used as a proxy for socioeconomic status.

Ms Erdman led the NHS Board through where NHSGGC collected data on the protected characteristics, how it was used to make improvements to services to tackle inequalities, and where there was still need to make progress. She summarised the following points:-

- Collection of patient data by protected characteristic and actions required to improve the collection;
- Using patient information on additional support needs to improve access and quality of service in Acute;
- Using equality data to monitor performance on tackling inequality and to drive change which would improve health outcomes;
- Using equality data to prevent ill health through screening;
- Using equality population data to plan services.

She alluded to the recommendations to achieve improvements and explained that it had been challenging to find measures that would close health gaps between groups, even though data was routinely collected on sex, age and socioeconomic status. This was further compounded by a lack of disaggregated data in many NHS data collection systems on other protected characteristics covered by the Equality Act 2010.

NHS Board Members commended the paper and the opportunities that collecting this data would provide. Some suggestions were made around the wording of some of the proposed equalities data collection and Ms Erdman agreed to take these on board. **Director of Planning & Policy**

In response to a question regarding public health screening programmes, Ms Renfrew explained that Public Health had reviewed its screening data to see where the data collected could be disaggregated by protected characteristics. The data had been used to identify low levels of uptake and late uptake by some groups in the population which could then be targeted with specifically tailored approaches. It was not the case that some people were "opting out" of the screening programmes themselves.

Ms Micklem was encouraged by recognition for the need for new data systems or migrated data systems to include the necessary fields to take forward this work. She encouraged the NHS Board to undertake an Equalities Impact Assessment (EQIA) on the systems themselves to see how best they could be developed. **Director of Planning & Policy**

In response to a question concerning the Community Health Index (CHI), it was reported that, as this was a national system, it could not be adapted locally. It was, however, hoped that, nationally, discussions would take place regarding the need for additional information on a person's CHI to include some of the data required by the Equality Act 2010.

Ms Brown suggested some advertising posters for members of the public to reassure them that these additional questions were being asked in an attempt to improve services and target specific groups. Ms Erdman agreed with this important point. **Director of Planning & Policy**

DECIDED

- That, the update on Equality Counts: Using Data to Understand and Tackle Inequality in NHSGGC report be received.

- That, the six recommendations for action to understand and tackle inequality in NHSGGC be supported.

Director of Planning & Policy

111. UPDATE ON GLASGOW IJB – SCHEME OF ESTABLISHMENT

A report of the Director of Planning and Policy [Board Paper No 15/65] asked the NHS Board to note the final Scheme of Establishment for the Glasgow City Integration Joint Board.

Ms Renfrew explained that, in January 2015, the NHS Board considered the draft Schemes of Establishment for the six Integration Joint Boards. The NHS Board gave the Director of Planning and Policy and the respective Chief Officers delegated authority to finalise and submit the Schemes. Five of the six Schemes had received SGHD approval. In relation to the one outstanding, Glasgow City, the remaining matter that the Chief Executives of the NHS Board and Council had been jointly working on since May 2015 had been the detail of scope and wording within the Integration Scheme in relation to specialist children's services.

Ms Renfrew summarised the four components of specialist children's services and reported that these services currently had dual arrangements with local management but also a line of accountability to a single general manager who had the responsibility and capacity to achieve working across the system, supported by singular Clinical Director posts for each service, also operating across the system. She outlined the whole system arrangements and the NHS Board's two objectives in the discussion with Glasgow City Council. The legal framework which underpinned the creation of Integration Joint Boards meant that these objectives could only be achieved by differentiating these services from those which were fully delegated and the revised draft Scheme of Establishment now achieved that. All matters that were highlighted by the SGHD following submission on 31 March 2015, which were largely textual and technical, had been resolved and agreed by both parties and civil servants.

Councillor Kerr confirmed that the revised draft Scheme had been submitted to Glasgow City's Executive Committee where it had been approved.

Director of Planning and Policy

In response to a question from Dr Reid concerning the definition and interpretation of "Acute Services", Ms Renfrew confirmed that this was set in legislation.

NOTED

112. HUB PROJECTS – UPDATE

A report of the Director of Facilities & Capital Planning, and the Head of Capital Planning & Procurement [Board Paper No 15/66] asked the NHS Board to note the updated programme for the delivery of Hub projects and the amendments to the Share Holder Agreement (SHA) and Territory Partnering Agreement (TPA) documentation between the NHS Board and Hubwest Scotland which would require to be agreed and signed in January 2016.

Mr Curran led the NHS Board through an update on the funding issues for Hub and the updated Hub programme. He described the funding background and discussions that had taken place between Scottish Futures Trust (SFT), the Scottish Government and the Office for National Statistics (ONS) on the changes that were required to the contract documentation to ensure that all projects were privately classified and off balance sheet. He provided a Hub programme update on the following:-

- Eastwood Health & Care Centre and Maryhill Health Centre;
- Woodside Health & Care Centre and Gorbals Health & Care Centre;
- Inverclyde Adult & Older People's Continuing Care Beds;
- Lennoxtown Community Hub;
- Greenock Health & Care Centre and Clydebank Health & Care Centre.

In response to a question concerning guaranteed revenue support, Mr White reported that it was likely the Schemes may cost more to the NHS Board but the challenge, at the moment, was that there was no clarity of the financial implications. It was recognised, however, that there was urgency to implementing the Inverclyde Adult & Older People's Continuing Care Scheme and SGHD had agreed to underwrite the inflationary increase caused by the delay. On that basis the scheme was moving towards financial close on 29 January 2016 and a commencement on site in March 2016.

NOTED

113. VALE OF LEVEN INQUIRY: UPADTE ON PROGRESS IN THE IMPLEMENATION OF THE RECOMMENDATIONS

A report of the Medical Director [Board Paper No 15/67] asked the NHS Board to note progress on implementation of the Vale of Leven Hospital Inquiry recommendations within NHSGGC.

The SGHD wrote to all NHS Boards asking that they implement the 65 NHS Board recommendations in the Vale of Leven Hospital Inquiry report and provide the SGHD with an update which was submitted in January 2015. The Scottish Government established an Implementation Group to oversee implementation of all 75 recommendations and a Reference Group was also established, with representatives of the patients and families of those affected, and the Group's role would be to support and challenge the Implementation Group.

The national Implementation Group was in the process of developing a national plan with timescales and milestones to show progress against each recommendation, and it was anticipated that SGHD would issue further guidance on this in early 2016.

Dr Armstrong reported that ten of the recommendations required further guidance from the SGHD and one required further guidance from the Crown Office and Procurator Fiscal Service. Of the remaining 64 recommendations, NHSGGC had fully implemented 47 and partially implemented 16. Good progress was demonstrated against those partially implemented with a number depending on progress of major developments.

A sub-group of the NHS Board's Infection Control Committee would convene in January 2016 to review ongoing progress and the further guidance from the SGHD. A subsequent update would be provided to the NHS Board meeting in February 2016. **Medical Director**

In discussion about seeking NHS Board assurance in the implementation of the recommendations, it was agreed that the Medical Director and Nurse Director work with four NHS Board Members (Chair, Mr J Brown, Vice Chair, Mr I Lee, Joint Chair of Staff Governance Committee, Ms M Brown and Ms S Brimelow, along with a representative from the Area Clinical Forum) to seek evidence and provide assurance on the implementation of each NHS Board's recommendation and timescale for completion of those currently partially completed. The outcome would be reported back to the NHS Board.

DECIDED

- That, a Short-Life Group be formed to seek assurance on the implementation and progress of the NHS recommendations and report back to the NHS Board later in the year. **Medical Director/ Nurse Director**

114. IMPLEMENTING THE CLINICAL SERVICES STRATEGY: CHANGES FOR 2015/16: DRUMCHAPEL HOSPITAL

A report of the Director of Planning & Policy [Board Paper No 15/68], asked the NHS Board to note the engagement and public consultation on changes to Older People's Services in North/West Glasgow (which reflected the Clinical Services Strategy approved by the NHS Board earlier in 2015 and was included in the 2015/16 Local Delivery Plan) and approve the transfer of rehabilitation beds, day hospital and outpatient services to Gartavel General Hospital from Drumchapel Hospital and the reprovision of NHS Continuing Care in other suitable locations across North and West Glasgow.

Ms Renfew set out the outcome of the public engagement and consultation on proposed changes to Older People's Services in North/West Glasgow and sought approval to proceed with the proposed service changes. It described the services and the drivers for change in that the Clinical Services Strategy established a clear framework to redesign, improve and modernise the NHS Board's Clinical Services. This approach was designed to ensure an individual's stay in hospital was for the Acute period of care only and that people were supported to return to their community as soon as possible.

Ms Renfrew summarised the engagement and consultation proposals in relation to rehabilitation and NHS Continuing Care, and explained that NHSGGC worked with the Scottish Health Council to develop an engagement and consultation process to facilitate the participation of a range of stakeholders in the discussions concerning the changes to Older People's Services in North/West Glasgow. She summarised the comments received and the key themes raised, explaining that it was proposed that the NHS Board proceed with the following:-

- Creation of a Rehabilitation Centre of Excellence at Gartnavel General Hospital and transfer rehabilitation inpatient, outpatient and day hospital services from Drumchapel Hospital to Gartnavel General Hospital.

- Closure of NHS Continuing Care Beds at Drumchapel Hospital.

In addition to the identified clinical benefits, the proposal generated a saving of £1.4m.

In response to a question from Ms Brimelow, Ms Renfrew outlined, in further detail, the proposals for NHS Continuing Care patients.

Although previously it had been agreed that 14 patients were likely to be transferred to Fourhills Nursing Home, feedback from families and relatives suggested that discussions should be made on an individual basis regarding a patient's placement

rather than all 14 being placed in Fourhills Nursing Home. That individual assessment and process would take place.

DECIDED

- That, the engagement and public consultation on changes to Older People's Services in North/West Glasgow, which reflected the Clinical Services Strategy approved by the NHS Board earlier in 2015 and included in the 2015/16 Local Delivery Plan, be noted.

- That, the transfer of rehabilitation beds, day hospital and outpatient services to Gartnavel General Hospital from Drumchapel Hospital and the reprovision of NHS Continuing Care to other suitable locations across North/West Glasgow, be approved. **Director of Planning & Policy**

115. NHSGGC 2014/15 ANNUAL REVIEW: SCOTTISH GOVERNMENT FEEDBACK LETTER AND ACTION NOTE

A report of the Head of Performance [Board Paper No 15/69] asked the NHS Board to note the 2014/15 Annual Review letter and Action Note from the Cabinet Secretary for Health, Wellbeing and Sport. The letter summarised the main points discussed and actions arising from the review and from the meetings which took place on 20 August 2015 as part of the review process.

Rev Dr Shanks was disappointed that there was no reference to many of the issues raised by Non-Executive Members of the NHS Board. He was encouraged, however, to see the intent to have meaningful engagement with local clinicians in taking forward both the critical health and social care integration agenda and other local service redesign programmes. Similarly, Dr Cameron welcomed this commitment, recognising that engagement with clinicians was key and one route to do this was via the Area Clinical Forum.

NOTED

116. NHS GREATER GLASGOW & CLYDE'S INTEGRATED PERFORMANCE REPORT (INCLUDES WAITING TIMES AND ACCESS TARGETS)

A report of the Head of Performance [Board Paper No 15/70] asked the NHS Board to note the content and format of the NHS Board's Integrated Performance Report.

Ms Mullen explained that this report brought together high-level system-wide performance information (including all of the waiting times and access targets previously reported to the NHS Board) with the aim of providing the NHS Board with a clear overview of the organisation's performance in the context of the 2015/16 Strategic Direction – Local Delivery Plan. An exceptions report accompanied all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and indicating a timeline for when to expect improvement.

The paper provided:-

- A summary providing a performance overview of current position.
- A single scorecard containing actual performance against target for all indicators. These had been grouped under the five strategic priorities identified in the 2015/16 Strategic Direction.
- An exception report for each measure where performance had an adverse variance of >5%.

Ms Mullen summarised performance and highlighted key performance status changes since the last report to the NHS Board including performance improvements, performance deterioration and measures rated as red.

NOTED

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

A report of the Director of Finance [Board Paper No 15/71] asked the NHS Board to note the financial performance for the seven month period to 31 October 2015.

Mr White reported that the NHS Board was currently reporting an overspend outturn against budget of £6.6m. At this stage, however, the NHS Board forecast that a year-end break even outturn would be achieved but that there were significant risks underpinning this forecast and it was conditional on the success in month 8 of current cost saving measures and identifying additional measures to further reduce expenditure or on securing sources of additional funding during the remainder of the year.

In response to a question from Mr Finnie, Mr White explained that the methodology for the notional set aside budgets for hospital services within the scope of Integration Schemes had now been agreed with the HSCPs. As Chair of the Audit Committee, Mr Finnie offered his support to look at these in more detail and as an assurance on behalf of the Audit Committee and the NHS Board. Mr White thanked Mr Finnie for the offer.

Director of Finance

In response to a question, Mr White reported that, during October 2015, the NHS Board received £5.477m of additional funding to deliver the Treatment Time Guarantee and reduce waiting times, and an additional £1.3m for winter pressures. The only other allocations received during the month were £0.835m from the Mental Health Innovation Fund and £0.123m to commission the Patient Portal.

In response to a question from Ms Brimelow regarding the current overspend outturn against budget, Mr White reported that ongoing analysis was taking place to seek to control the causes of overspend in the region of £1m per month.

NOTED

118. HEALTHCARE IMPROVEMENT SCOTLAND: OLDER PEOPLE IN ACUTE CARE UNNANNOUNCED INSPECTION: QUEEN ELIZABETH UNIVERSITY HOSPITAL AND LANGLANDS UNIT (7-11 SEPTEMBER 2015)

A report of the Nurse Director [Board Paper No 15/73] asked the NHS Board to note the HIS report, the improvements and actions taken and agree that an update report on Older People's Care would be presented to the NHS Board in six months' time.

Dr McGuire summarised the Healthcare Improvement Scotland (HIS) Inspection report from its unannounced inspection to the Queen Elizabeth University Hospital (QEUH) from Monday 7 to Friday 11 September 2015. The inspectors visited eight wards in the QEUH and five wards in the Langlands Unit. She led the NHS Board through the areas of good practice identified as well as areas for improvement, particularly on the Langlands Unit where specific concerns were raised in relation to wards 56 and 57.

In looking at the main issues identified, Dr McGuire explained that actions necessary to address the recommendations were being taken forward in a multidisciplinary approach in order to ensure that the necessary actions and improvements were being taken forward across NHSGGC. She provided an outline of some of the improvement work that had been taking place prior to the inspection and ongoing, including:-

- Documentation;
- Falls;
- Pressure area care;
- Food, fluid and nutrition;
- Person-centred care;
- Delirium;
- Adults with Incapacity, Do Not Attempt Cardiopulmonary Resuscitation and Medicines Reconciliation.

In response to a question, Dr McGuire emphasised that staff in the Langlands Unit were particularly concerned by the findings of the report and the impact it may have on their patients and families. Senior staff were supporting them and putting in place positive interventions. Staff were very keen to make improvements and work in an multi-disciplinary way to ensure quality care, outcomes and patient satisfaction.

In response to a question from Ms Brimelow, Dr McGuire outlined that the report and resulting media coverage caused significant public anxiety and had upset staff in the stroke wards of the Langlands Unit. The report's description of the care of two patients in particular, had caused concern especially as the NHS Board had provided a full explanation of the circumstances. Dr McGuire informed the NHS Board that she had shared their concerns and raised them with HIS and the SGHD Chief Nursing Officer. Dr McGuire welcomed the offer from Ms Brimelow to be involved in the group looking at the issues raised and would report back to the NHS Board on GGC-wide improvements in August 2016. **Nurse Director**

DECIDED

- That, the contents of the HIS report be noted.
- That, the improvements and actions taken be noted.
- That, an update report on Older People's Care come to the NHS Board in six months' time be agreed. **Nurse Director**

119. QUARTERLY REPORTS ON COMPLAINTS AND FEEDBACK: 1 JULY TO 30 SEPTEMBER 2015

A report of the Nurse Director [Board Paper No 15/72] asked the NHS Board to note the quarterly reports on complaints and feedback in NHSGGC for the period 1 July to 30 September 2015, as well as extracts from the ISD and SPSO's Annual Reports 2013/14.

Complaints handling performance had been 79% of complaints responded to within 20 working days achieved against a target of 70%.

The paper referred to the patient, carer and public feedback report which looked at feedback, comments and concerns received centrally and in local services and identified service improvements and ongoing developments. It noted the issues attracting most complaints in the Partnerships and the Acute Services Division which centred around clinical treatment and the attitude and behaviour of staff and touched on how NHSGGC was taking forward system learning from complaints and feedback as well as from recommendations made in the Scottish Public Services Ombudsman (SPSO) reports.

Ms Micklem asked about the self assessment outcome in relation to the Participation Standards 2014/15. Mr Hamilton explained that the Scottish Health Council had completed its final analysis of NHSGGC's self assessment of two sections of the Participation Standard and agreed that both were level ones (developing). This reflected the NHS Board's aspiration to reorganise its complaints function into a more centralised way with the intention of leading to an improved performance and consistency NHS Board-wide.

In response to a question from Mr I Fraser regarding the continued increase in prison complaints, Dr McGuire reflected that this was Scotland-wide and NHSGGC had been asked to be one of the pilot NHS Boards to look at how better engagement can take place with the prisoner population around their health services. NHSGGC looked forward to being part of that process, and details, as they emerged, would be included in future reports. **Nurse Director**

Dr Lyons referred to feedback relating to single room provision at the QEUH and, in response to his question, Dr McGuire described how staff worked/positioned themselves around the hospital floors to achieve maximum visibility.

NOTED

120. AREA CLINICAL FORUM MINUTES: 1 OCTOBER 2015

The minutes of the Area Clinical Forum meeting held on 1 October 2015 [ACF(M)15/05] were noted.

NOTED

121. PHARMACY PRACTICES COMMITTEE MINUTES: 28 OCTOBER 2015

The minutes of the Pharmacy Practices Committee meeting held on 28 October 2015 [PPC(M)2015/02] were noted.

NOTED

122. CLOSING REMARKS

The Chair wished all Members and those in attendance a very merry Christmas and best wishes for 2016.

The meeting ended at 1:10pm.

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

NHS GREATER GLASGOW AND CLYDE

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

PRESENT

Mr J Brown CBE (in the Chair)

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

IN ATTENDANCE

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

ACTION BY

73. WELCOME AND APOLOGIES

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

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

NOTED

74. DECLARATION(S) OF INTEREST(S)

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

NOTED

75. CHAIR'S OPENING REMARKS

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

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

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

NOTED

76. MINUTES

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

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

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

NOTED

77. MATTERS ARISING FROM THE MINUTES

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

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

NOTED

78. PROPOSED APPROACH TO ENGAGEMENT ON SERVICE CHANGES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The move against the recommendation therefore, fell.

DECIDED

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

Director of Planning & Policy, Nurse Director, Medical Director

79. NHSGGC UNSCHEDULED CARE PROGRAMME – AUGUST 2016

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

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

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

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

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

Deputy Medical Director/ Programme Director, Unscheduled Care Review

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

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

NOTED

80. TRANSITION TO HOSPITAL BASED COMPLEX CARE: UPDATE

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

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

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

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

NOTED

81. CARERS ACT COMMENCEMENT DATE

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

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

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

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

DECIDED

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

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

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

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

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

DECIDED

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

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

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

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

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

DECIDED

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

84. IMMUNISATION PROGRAMMES IN NHSGGC 2015-2016

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

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

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

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

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

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

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

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

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

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

NOTED

85. CLINICAL GOVERNANCE ANNUAL REPORT 2015/16

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

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

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

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

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

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

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

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

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

NOTED

86. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 16/53] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHSGGC on a range of key HAI indicators at national and individual hospital site level and led the NHS Board through a summary of performance in relation to:-

- Staphylococcus Aureus Bacteraemias (SABs)
- Clodistrium Difficile (C.Diff)
- Surgical Site Infection (SSI) rates for caesarean section, knee anthroplasty, repair of neck of femur procedures and hip anthroplasty procedures
- The Cleanliness Champions Programme
- Healthcare Environment Inspectorate (HEI) inspections

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

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

NOTED

87. NHSGGC'S INTEGRATED PERFORMANCE REPORT

A report of the Head of Performance [Board Paper No 16/54] asked the NHS Board to note the content and format of the NHS Board's Integrated Performance Report.

Ms Mullen explained that this report brought together high-level system-wide performance information (including all of the waiting times and access targets previously reported to the NHS Board) with the aim of providing the NHS Board with a clear overview of the organisation's performance in the context of the 2015/16 Strategic Direction approved Local Delivery Plan. An exceptions report accompanied all indicators with an adverse variance of 5% or more, detailing the actions in place to address performance and indicating a timeline within which performance would improve.

Ms Mullen provided:-

- A summary providing a current performance overview.
- A single scorecard containing actual performance against target for all indicators. These had been grouped under the five strategic priorities identified in the 2015/16 Strategic Direction.
- An exception report for each measure where performance had an adverse variance of >5%.

Ms Mullen summarised performance and highlighted key performance status changes since the last report to the NHS Board including performance improvements, performance deterioration and measures rated as red.

NOTED

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

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

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

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

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

against plan.

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

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

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

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

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

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

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

NOTED

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

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

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

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

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

NOTED

90. ACUTE SERVICES COMMITTEE MINUTES: 17 MAY 2016

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

NOTED

91. AREA CLINICAL FORUM MINUTES: 2 JUNE 2016

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

NOTED

92. AUDIT COMMITTEE MINUTES: 21 JUNE 2016

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

NOTED

93. ANY OTHER BUSINESS

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

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

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

The meeting ended at 1:25pm.

NHSGG&C(M)17/03
Minutes: 41 - 63

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Boardroom, JB Russell House, Gartnavel Campus, Glasgow, G12 0XH on Tuesday, 27 June 2017 at 9.30am.

PRESENT

Mr J Brown CBE (in the Chair)

Dr J Armstrong [To Minute 56]
Cllr C Bamforth
Ms M Brown
Dr H Cameron
Mr S Carr [To Minute 53]
Cllr J Clocherty [To Minute 56]
Dr L de Caestecker
Mr A Cowan
Mr R Finnie
Ms J Forbes
Mr I Fraser
Ms J Grant
Dr D Lyons
Mr J Matthews OBE
Cllr S Mechan [to Minute 50]
Mr A Macleod
Ms T McAuley OBE
Mrs D McErlean
Dr M McGuire
Cllr I Nicolson [To Minute 56]
Mr I Ritchie
Mr M White

IN ATTENDANCE

Ms A Baxendale	Head of Health Improvement [From Minute 58 to 59]
Ms J Erdman	Head of Equalities and Human Rights [For Minute 57]
Ms M Farrell	Director, Clyde Sector
Mr J C Hamilton	Head of Administration
Mr D Harley	Planning & Performance Manager, Mental Health Services [For Minute 51]
Mr D Leese	Chief Officer, Renfrewshire HSCP
Ms L Long	Chief Officer, Inverclyde HSCP [To Minute 50]
Mr D Loudon	Director of Property, Procurement and Facilities Management
Ms S Manion	Chief Officer, East Dunbartonshire HSCP [To Minute 56]
Ms T Mullen	Head of Performance [To Minute 56]
Mr D McConnell	Assistant Director (Audit Scotland) [For Minute 49]
Mr A McLaws	Director of Corporate Communications [To Minute 56]
Mrs A MacPherson	Director of Human Resources & Organisational Development
Mr P Ramsay	Assistant Director of Finance [From Minute 46 to 49]
Mr K Redpath	Chief Officer, West Dunbartonshire HSCP
Mr B Skelly	General Manager Strategic Assets [For Minute 50]
Ms M Smith	Secretariat Manager
Dr D Stewart	Deputy Medical Director [For Minute 53]
Mr D Williams	Chief Officer, Glasgow City HSCP

ACTION BY

41. WELCOME AND APOLOGIES

Mr Brown extended a welcome to Ms Audrey Thompson who was recently elected as Chair of the Area Clinical Forum and will become a Non – Executive Board Member

from 1 July 2017 and to Ms M Farrell, who attended the meeting on behalf of the Interim Chief Operating Officer for Acute Services Division (ASD). Mr Brown also noted the recent appointment of Cllr J McColl, Leader of West Dunbartonshire Council to the Board.

Apologies for absence were intimated on behalf of Mr Best, Ms S Brimelow OBE, Ms J Donnelly, Professor Dame A Dominiczak, Cllr M Hunter, Ms M A Monaghan, Cllr J McColl and Ms R Sweeney.

NOTED

42. DECLARATIONS OF INTEREST

The following declarations of interest were raised:-

- Mr Finnie – Agenda Items 17 "Weight Management" and 18 "Retail Policy" in relation to his appointment as Chair of Food Standards Scotland.

- Ms Grant – Agenda Item 3(b) in relation to the National Review of Maternity & Neonatal Services as Chair of the National Review Group.

NOTED

43. MATTERS ARISING FROM THE MINUTES

(a) The Board Rolling Action List [Board Paper No. 17/19] was noted with four actions recommended for closure and three still outstanding.

Mr White provided Members with an update in relation to work ongoing in regard to the NHS Board's financial plan for 2017/18. On 26 June, Ms Grant and Mr White had met with Scottish Government colleagues. Mr White had written last week to the Integrated Joint Boards (IJBs) highlighting the progress made, and meetings had taken place with two Chief Officers of the IJBs to explore propositions. A meeting was scheduled to take place on 27 June 2017, following the Board Meeting, with Ms Grant, Mr White and Chief Officers of the IJBs. Mr White would report back to the Board with an update following this meeting. **Director of Finance**

Mr Carr noted that governance concerns had been expressed at the last Board meeting, and in view of these concerns it would be helpful to have a written update from Mr White. This would be covered in the next financial monitoring report to the NHS Board. Ms McAuley noted that Glasgow City IJB had not yet received the written update from Mr White, while noting that the ongoing process appeared to be positive. Mr White noted that this was reflective of the situation, and that he would circulate the written update. **Director of Finance**

(b) NATIONAL REVIEW OF MATERNITY & NEONATAL SERVICES: IMPACT ASSESSMENT (INCLUDING COMMUNITY MIDWIFE UNITS – SELIVERY UNITS – UPDATE

A paper from the Nurse Director [Board Paper No. 17/20] asked the NHS Board to note that the National Maternity and Neonatal Strategy – Five Year Forward Plan had

76 recommendations setting out a new model of care across Scotland; and that steps have been taken to map out the NHSGGC position against these recommendations. Further, to agree that NHSGGC adopt the key principles of the National "Best Start" report and during 2017/18, develop an Implementation Plan with an evaluation of the impact this would have on the redesign of maternity care and outcomes. The paper asked the NHS Board to agree that the position of Inverclyde Royal Hospital (IRH) and the Vale of Leven Hospital (VoL) Community Midwife Units (CMUs) was to pause on any steps to undertake formal public consultation in relation to the Birthing Service while this review/redesign work was undertaken; and note that NHSGGC would review the position at a later date.

Dr McGuire led Members through the paper including the background and decision taken at the NHS Board Meeting in February 2017, to make a comprehensive assessment of the National Strategy and map out the NHSGGC position in this regard. Dr McGuire outlined the key principles of "Best Start" marking the change from previous maternity reviews, and provided an overview of the NHSGGC proposal to implement the principles of the National report detailing the scope of this work.

Mr Brown thanked Dr McGuire for this helpful summary of the key issues, and noted the extent of the stakeholder involvement in this process encompassing patients and carers as well as staff. Ms Grant added that this was a fundamentally different model emphasising continuity of care which was what women had asked for, with a small team approach being to the fore. Whilst there would be less variation within CMUs, these should still be able to reflect local needs.

Mr Carr asked about the timescale for this review. Ms Grant advised that the National Implementation Board had met at the beginning of June 2017, and there would be regional and local engagement to follow. Health Boards had been advised to await the outcome of this process and an update would be brought back to a meeting of the NHS Board. **Nurse Director**

In response to a comment from Cllr Clocherty in regard to the lateness of papers for this meeting, Ms Grant acknowledged the volume of papers, and that Executive Officers would endeavour to circulate papers timeously going forward. **Head of Administration**

Cllr Clocherty asked about the red pathway especially in relation to Inverclyde. Ms Grant noted that many women had advised that they found the red pathway unhelpful especially as their circumstances could change throughout the course of their pregnancy. It was difficult to be firm in respect of the timescale given the nature of the work to be carried out nationally and locally over a five year period. Dr McGuire echoed that women's health could either improve or deteriorate during their pregnancy, and that women would welcome decision making in terms of risk later in the pregnancy thus offering a more holist approach.

Ms McAuley noted the good strategic fit of the proposal with the national position and that this was the right direction of travel, and asked for more reassurance for the Clyde area in terms of capacity and safety in the delivery of the current service. Dr McGuire advised that the Birthing Services at IRH and VoL were operating at the agreed staffing complement levels and that midwives were updating training at Royal Alexandra Hospital (RAH). Dr McGuire underlined that safety of care was of paramount importance and this would not be compromised at either site.

Mr Ritchie asked what assurance there would be that the number of births at the CMUs would increase over time. The desire for choice of pathways was emphasised and the

new model offered a choice of different pathways around the country.

Ms Brown welcomed the pause on the consultation regarding the CMUs, noting the need to clearly define the CMUs, and Birthing Services, as well as home births, and the clinical picture surrounding each pathway, so that women could make informed choices.

Mr Brown noted the public interest in the CMUs and Mr McLeod added that the local communities in Clyde should be part of this review noting the uncertainty experienced. Mr Brown agreed that this was an area in which the Director for Communications could lead in explaining the process.

Mr Brown noted that a detailed update should come back to the NHS Board. It was noted that the National Maternity and Neonatal Strategy – Five Year Forward Plan has 76 recommendations setting out a new model of care across Scotland; and that steps have been taken to map out the NHSGGC position against these recommendations. It was noted that NHSGGC would review the outcomes of implementation. **Director of Communications**

DECIDED

- That NHSGGC adopt the key principles of National "Best Start" report and during 2017/18 be agreed. **Nurse Director**
- That an Implementation Plan with an evaluation of the impact this would have on the redesign of maternity care and outcomes be developed. **Nurse Director**
- That the position on the Inverclyde Royal Hospital (IRH) and the Vale of Leven Hospital (VoL) Community Midwife Units (CMUs) formal public consultation in relation to the Birthing Units was paused while this review/ redesign work was undertaken. **Nurse Director**

44. CHAIR'S REPORT

Mr Brown reported that he had attended the NHS Board Chairs' Meeting which had reviewed the transformation of health and social care delivery in NHS Scotland, noting the role of Non Executives Board Members in this.

Mr Brown had attended the Audit Committee noting the extensive, detailed work carried out there in preparation for the NHS Board end of year accounts.

Mr Brown advised that he had met with Ms J Erdman regarding meeting the requirements of equality legislation in relation to the appointment of Board Members. He had also discussed this with Mr I Bruce (Public Appointments Manager, Commission for Ethical Standards in Public Life in Scotland). These discussions focussed on the difference diversity could make in the governance of public bodies.

Mr Brown had met with the Cabinet Secretary for Health and Sport at the first sod cutting for Gorbals Health & Social Centre which represented £17m investment. Taken in conjunction with the other developments at Eastwood, Pollokshields, Maryhill and Possilpark; as well as the new developments for Parkhead, Woodside, Greenock and Clydebank, there was significant investment in health and social care partnerships throughout NHSGGC.

As part of their programme of engagement with local stakeholders, Mr Brown and Ms Grant had met with local MSP Rona McKay.

Finally, Mr Brown had attended the Remuneration Committee to review performance and set objectives for the NHSGGC Executive Team for 2017/18.

NOTED

45. CHIEF EXECUTIVE'S REPORT

Ms Grant advised that she had attended the Area Medical Committee, and underlined the importance of engagement with the professional advisory committee framework in delivering transformational change across the NHS Board.

Ms Grant updated the Board on her regular communication with the Scottish Government, particularly in relation to the NHS Board's financial position, waiting times, and the Local Delivery Plan.

Ms Grant had attended the NHS Scotland Event with Shirley Rodgers (Workforce and Strategy Director NHS Scotland) and the Cabinet Secretary for Health and Sport on 20th June, there had been a meeting with the Royal Colleges in relation to the NHSGGC Unscheduled Care Review, and this had provided positive feedback from clinical colleagues.

Ms Grant had also attended the Executive Leadership review led by NHS Education for Scotland.

The NHS Board Meeting was adjourned.

46. ENDOWMENTS FUNDS ACCOUNTS TO 31 MARCH 2017

Mr Brown convened a meeting of the Trustees of the Endowment Funds.

A paper of the Director of Finance [Board Paper No. 17/21] asked the Trustees to adopt the Endowment Funds Annual Accounts for the financial year ended 31 March 2017; and to authorise the Director of Finance to sign the Statement of Trustees Responsibilities and Balance Sheet.

A draft set of accounts was presented by Mr White for the Trustees' approval and this followed detailed scrutiny at the NHS Board's Audit and Risk committee on 20 June 2017. It was noted that the Endowment Funds Accounts required to be approved prior to being presented to the NHS Board for their approval. Mr White noted the total value of funds to be £86.8m, compared to £83.3m in the previous year. There were gains on investment and new fund managers had been appointed effective from 1 April 2017. The Auditors anticipated issuing an unqualified opinion subject to final sign off of the financial statements.

Mr Macleod, Chair of the Audit Committee, confirmed the detailed scrutiny the Committee had taken on behalf of all Trustees with a recommendation that the accounts be approved and signed.

Ms McErlean noted that there was an error and her name should be included on the list of Trustees. Mr White agreed to update the paper. **Director of Finance**

DECIDED

- That the Endowment Funds Annual Accounts for the financial year ended 31 March 2017 be adopted. **Director of Finance**

- That the Director of Finance be authorised to sign the Statement of Trustees Responsibilities and Balance Sheet. **Director of Finance**

The meeting of the Trustees was concluded and the NHS Board Meeting was re-convened.

NHS Board Meeting

47. GOVERNANCE STATEMENT 2016/17

A paper of the Chair of the Audit Committee [Board Paper No. 17/22] asked the NHS Board to consider and note the attached Statement of Assurance by the Audit Committee; and approve the Governance Statement (which was part of the Annual report and Accounts to 2016/17) for signature by the Chief Executive. It was noted that the format of the Governance Statement and its contents were specified in guidance issued by the Scottish Government.

The Internal Auditor's Annual Report noted that controls were generally satisfactory with some improvements required. Mr Macleod advised that Action Plans had been put into effect in these areas relating to enhancing the adequacy and effectiveness of the framework of governance risk management and control. The Audit and Risk Committee had scrutinised this in detail and considered that there had been a satisfactory system of internal control in place within NHSGGC throughout 2016/17.

Mr Brown thanked Mr Macleod for this overview, and the Statement of Assurance by the Audit Committee was noted.

DECIDED

- That the Governance Statement (which was part of the Annual Report and Accounts to 2016/17) for signature by the Chief Executive be approved.

48. ANNUAL REPORT AND CONSOLIDATED ACCOUNTS 2016/17

A report of the Director of Finance [Board Paper No. 17/23] asked the NHS Board to adopt and approve the Annual Report and Consolidated Accounts for the year ended 31 March 2017 for submission to the Scottish Government; to authorise the Chief Executive to sign the Performance report and the Accountability Report; and the Chief Executive and the director of Finance to sign the Consolidated Balance Sheet.

Mr White thanked Mr Macleod and the Members of the Audit and Risk Committee for their detailed scrutiny work in Committee in June 2017. Mr White provided an overview for Members of the Accounts split into two main parts as a Performance Report and Accountability Report. Mr Macleod provided assurance to Members of the in depth scrutiny carried out by the Audit and Risk Committee, recommending that Members accept and approve the Annual Report and Consolidated Accounts.

Ms McAuley suggested that it should be noted that the agreement had not yet been concluded with the IJBs in terms of their budgets for 2017/18. Mr White stated that a note would be added in terms of transparency in regard to the conclusion of agreement with the IJBs. **Director of Finance**

Mr Finnie offered thanks to the Finance team as well as NHSGGC staff generally in view of the number of transaction carried out each year across the Board which demonstrated the safe use of public funds under staff control.

DECIDED

- That the Annual Report and Consolidated Accounts for the year ended 31 March 2017 for submission to the Scottish Government be approved. **Director of Finance**
- That the Chief Executive be authorised to sign the Performance Report and the Accountability Report. **Chief Executive Officer**
- That the Chief Executive and the Director of Finance be authorised to sign the Consolidated Balance Sheet. **Chief Executive Officer / Director of Finance**

49. ANNUAL REPORT FOR THE BOARD OF NHSGGC AND AUDITOR GENERAL FOR SCOTLAND 2016/17

A report of the Assistant Director, Audit Scotland [Board Paper No. 17/24] asked the Board to note the report on the 2016/2017 audit of NHSGGC. It was noted that this report had been reviewed by the Director of Finance and scrutinised by the Audit and Risk Committee.

Mr D McConnell, in his role as Assistant Director of Audit Scotland, led Members through the report, highlighting financial management, financial sustainability, governance and transparency and value for money.

Mr Carr requested clarification on financial management in relation to the operating surplus recorded by the IJBs and Mr White confirmed that these reserves were held by the IJBs.

Ms Brown noted that the report was succinct and helpful and noted the continuing challenge to the Board of delivering savings whilst continuing to deliver services, and raised a question in respect of a new system for data collection. Mr White noted that this was planned to be operational during the second quarter of 2017/18.

Ms Brown also suggested that it would be helpful for the NHS Board to receive a note of reports from Audit Scotland through the financial year, as item for information, and Mr White agreed to do. **Director of Finance**

Ms McAuley asked for an update on the timing of the next meeting of the Finance and Planning Committee. Mr White confirmed that new dates were being explored in advance of the next scheduled meeting on 22 August 2017.

NOTED

50a. APPROVAL OF PAMS (PROPERTY ASSET MANAGEMENT STRATEGY)

A report of the Director of Property, Procurement and Facilities Management [Board Paper No. 17/25] asked the NHS Board to approve the Property and Asset Management Strategy 2016/2020 (PAMS) for submission to Health Facilities Scotland.

Mr Skelly led Members through the report covering the Board estate, and highlighted that the overall purpose of PAMS was to ensure that the Board's assets could respond to continuing organisational and service requirements through fitness for purpose and positive support to service delivery.

Mr Skelly highlighted the key metrics of the NHS Board estate including age, tenure, building condition, functional sustainability, quality and space ranking. He also provided an overview of the backlog maintenance for the Board's estate. Mr Skelly noted that the Capital Plan, included in PAMS, had been approved by the NHS Board at the meeting held on 15 June 2017. Mr Skelly advised Members that the six IJBs were each developing an estate strategy and working closely with colleagues in the NHS Board to do so.

Cllr Nicolson asked for clarification in respect of the timescale for delivery of the strategy, as well as assurance in regard to whether a reduction in backlog maintenance could impact on parts of the Board's estate and it becoming unfit for purpose over time. Mr Loudon advised that the challenge was to prioritise spending for future capital investment, balanced by spending on building maintenance. NHSGGC had to prioritise backlog maintenance in context of existing resources.

Mr Brown asked if it was possible to place a timescale on the Board becoming up to date in backlog maintenance, and Mr Loudon outlined that the Capital Plan covered investment in maintenance over the next three years. However, eradication of all maintenance would be a much longer term project.

Ms Grant emphasised that the development of the NHS Board's strategic plan for transformation in the delivery of services would include consideration of rationalisation of the Board's estate, with a need for lateral thinking for pinpointing investment. A balanced plan was required to achieve optimal access to services across the NHS Board including the IJBs. Mr Brown noted that the impact of this new strategy would inform the NHS Board's position in this area, and that there would be a continued focus on backlog maintenance.

Ms Brown commended the work carried out in relation to the Mental Health programme, and queried why Children and Adult Mental Health services were being placed within Rowanbank Clinic as noted in the paper. Mr Loudon stated that this was an error within the report which would be amended. **Director of Property, Procurement and Facilities Management**

Cllr Clocherty asked for clarification regarding detailed review of two sites (Royal Alexandra Hospital and Inverclyde Royal Hospital). Mr Loudon confirmed that this was because as each of these sites had a high percentage of maintenance backlog; the risk presented was subject to detailed review.

In answer to a question from Mr Carr in respect of £10m spend on the Queen Elizabeth University Hospital, Mr Loudon clarified that this was for improvement to the whole campus rather than the QEUH alone.

Mr Macleod noted that the report also included eHealth and medical equipment and

asked about pace of replacement and whether the programme in respect to disposals could be accelerated to realise funds. Mr Loudon stated that there had been prioritisation of investment in key medical equipment and Mr Edwards advised that within eHealth there was a similar prioritisation of investment in key areas. Mr White advised that property disposals were indeed being accelerated with Dykebar Hospital expected to be marketed in July 2017 and the Yorkhill site in late 2018/2019.

DECIDED

- That the Property and Asset Management Strategy 2016/2020 (PAMS) for submission to Health Facilities Scotland be approved.

50b. FIRE SAFETY – UPDATE

Mr Loudon updated the NHS Board on the review carried out of the NHS Board's estate specifically in reaction to the lessons learned from the Grenfell Tower disaster. A report was to be submitted to Health Facilities Scotland on 28th June 2017.

There was a particular focus on buildings over 18 metres high, and this included the QEUH. Mr Loudon provided assurance to Members that the cladding and insulation used were fully compliant with Scottish Building Standards approved by Building Control during the design stage of the project. Cladding had also been used in the recent renovation the Institute of Neurological Sciences, and it was confirmed that this was compliant with building regulations. A decision had been taken to review all buildings within the Board and HSCPs, and to date no issues of concern had been raised.

Mr Brown noted that assurance would be provided to staff through the Communications Team and asked for a written update to come to the NHS Board at the August 2017 Board meeting.

Director of Communications / Director of Property, Procurement and Facilities Management

Mr Brown offered condolences on behalf of the NHS Board, to the families affected by the Grenfell Tower disaster, and other recent terrorist related incidents, as well as noting the great work achieved by the emergency services, including the NHS.

51. OUTLINE BUSINESS CASE: MENTAL HEALTH - 2 WARDS – DESIGN, BUILD, FINANCE & MAINTAIN SCHEME

A report of the Chief Officer of Glasgow City HSCP [Board Paper No. 17/25b] asked the NHS Board to approve the Outline Business Case (OBC) for onward submission to the Scottish Government Capital Investment Group (CIG); note the preferred option for two new build wards; note the scheme was value for money, affordable and achievable; note the scheme was bundled with two other schemes procured through the Hub West Design, Build, Finance and Maintain (DBFM) route.

Mr Williams led Members through the paper explaining that this followed the NHS Board's decision to approve the Initial Agreement paper in August 2016. Agreement to the proposal would result in a reconfigured mental health in-patient service in North Glasgow which would address clinical isolation, reduce pressure on the Out of Hours rota and avoid the unpredictable and potentially expensive use of care home accommodation costs. Consideration of a range of proposals had led to this being the optimal route proposed.

Mr Carr asked about bedroom size which had been indicated as optimal at 16 square metres but were then detailed in the proposal at 13.5 square metres. Mr Harley clarified that this was due to the overall square meterage. Although the proposed bedroom size was smaller than the current gold standard, engagement work had been carried out to ensure that the patient's needs as well as clinical support needs could be met within this room size.

Dr Lyons asked that the terms "organic disease" when made in reference to dementia, and "forensic disease" be removed, and this was agreed. Dr Lyons also noted that it would be inappropriate to accommodate older dementia patients with older people suffering from other mental health issues. Mr Harley confirmed that there would not be a mixed ward, and that there would be a separate dementia ward.

Chief Officer, Glasgow City HSCP

DECIDED

- That the Outline Business Case (OBC) for onward submission to the Scottish Government Capital Investment Group (CIG) be approved.
- That the preferred option for two new build wards be noted.
- That that the scheme was value for money, affordable and achievable was noted.
- That the scheme was bundled with two other schemes procured through the Hub West Design, Build, Finance and Maintain (DBFM) route be noted.

52. UNSCHEDULED CARE REVIEW

A report of the Medical Director [Board Paper No. 17/31] asked the Board to note the key recommendations of the Unscheduled Care Review report to improve unscheduled care performance in line with Scottish Government targets for the NHS Board.

Dr D Stewart provided Members with a high level summary of the report and key recommendations to deliver a targeted work programme for 2017/18. This included a summary of occupancy rates and estimated bed requirements, noting the aim to meet occupancy rates of 85% for unscheduled care beds which would lend an appropriate level of flexibility. The report did not advocate increasing bed numbers and this was in the context of the shift from acute to community care in the overall strategy of the NHS Board. The key was to make best use of beds, and target in-patient beds for those who had clinical need for an in-patient stay.

Dr Stewart provided comparison of Emergency Department admission rates compared to other Health Boards. As well a population level analysis demonstrating that NHSGGC had higher admission rates per 1000 residents than peer Health Boards in Scotland for the same specialities.

The key recommendations related to better management of current in-patient capacity; alternatives to admission through condition specific pathway alternatives; emergency department process change; a robust escalation policy as well as eHealth and infrastructure to deliver unscheduled care change. Dr Stewart detailed alternatives to admission e.g. single front door for emergency triage as well as ambulance emergency care pathways, aimed at routing patients to the correct care as soon as possible. Further, better use of ambulatory care as well as care home opportunities.

Ms Brown noted that it was helpful to receive a distilled overview of the report and asked when the implementation plan would be available for review. Dr Stewart advised that this was underway, and that much of the work detailed in the report had already been put into action.

Dr Cameron referred to the change in culture and decision–making that the report highlighted which would help to enforce change. She noted the positive engagement with staff, and Dr Stewart confirmed that the report had been shared with clinical colleagues and had been well received.

In answer to a question from Ms McAuley on whether the report was cost neutral especially referring to consultant cover, Dr Stewart confirmed that the paper did not rely on any significant investment, and that there was a strong belief that these recommendations would be financially more efficient.

Dr Armstrong underlined the amount of work that was already underway e.g., frail elderly pathway at the QEUH. A Joint Implementation Board was required with the IJBs. It was agreed that Dr Armstrong would report to the NHS Board in August with an update on the work already underway and setting out a planning process with appropriate timescale. **Medical Director**

Mr Ritchie asked for a view on whether it was possible to identify the areas that would present a challenge to the success of the project. Dr Stewart highlighted reviews carried out of the processes that had been successful in other Health Boards, to optimise forward planning whilst at the same time accepting the challenge to put improvement work in place at the same time as continuing delivery of services.

Mr Brown suggested that staff engagement as well as public understanding and acceptance would be critical to the successful implementation of the report's recommendations.

NOTED

53. NHS GREATER GLASGOW & CLYDE INTEGRATED PERFORMANANCE REPORT

A report of the Head of Performance [Board Paper No. 17/26] asked the Board to note and discuss the content of the Board's NHS report. This paper brought together high level information from several reporting strands to provide an integrated overview of the Board's performance in the context of the 2016/17 Strategic Direction and Local Delivery Plan.

Ms Mullen summarised performance and highlighted key performance status changes since the last report to the NHS Board including performance improvements, performance deterioration and measures rated as red (where performance has had an adverse variance of more than 5%).

Ms Mullen noted improvement in performance in relation to the overall number of delayed discharges; access to alcohol and drug treatment and that performance in relation to the overall Stroke Care Bundle was beginning to demonstrate an improvement.

There had been performance deterioration in the number of patients waiting longer than national waiting time standards; there were ten measures rated as red and each had an accompanying exception reports, outlining actions in place to address performance.

Ms Brown highlighted the detect cancer early rates as concerning, particularly in relation to breast cancer and urology, and asked if it would be possible to include data on diagnoses made symptomatically as well as through screening programmes, to give a more detailed picture. Ms Brown also highlighted the pathway issues in Upper GI, delayed discharge in mental health

Dr De Caestecker advised that additional information could be provided in relation to both screening and symptomatic services. **Director of Public Health**

Ms Grant advised that capacity planning was under way in Upper GI, urology and diagnostics testing where a board wide referral system was being considered. Ms Farrell added that the complexity of testing for Upper GI patients impacted the pathways. The Director of Regional Services had recently attended a national review in this respect and the Sector Directors were working closely to focus on cancer targets. There could be lessons to be taken from the Safety Huddle Model as good practice.

Mr Williams agreed to provide an update in relation to Mental Health delayed discharges in the next report to the Board. Mrs MacPherson confirmed that there had been some improvement in relation to staff absences notably within acute services. **Chief Officer Glasgow City HSCP**

Ms McAuley noted an improvement in the overall quality of Board papers, with pro-active activity and confirmation that issues were being acted upon. Dr Cameron welcomed the work carried out on capacity and queried whether the NHS Board was looking at alternative outpatient modelling. Ms Grant confirmed that efficiency was being reviewed across specialties. Lastly, Dr Armstrong noted the good work on self care, as well as MSK Physiotherapy, to help reduce demand for acute Hospital care.

NOTED

54. CLINICAL GOVERNANCE REPORT – UPDATE

A report of the Medical Director and the Nurse Director [Board Paper No. 17/27] asked the Board to note the key messages on areas where assurance was required.

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

Within clinical safety, Dr Armstrong highlighted the revision of the Significant Clinical Incident Policy. The Consent Policy had been reviewed in light of the recent Montgomery ruling. Dr Armstrong updated Members in regard to the Mental Health Safety Programme and the reductions seen in reported violent episodes and noted the work being carried out by the Thrombosis Committee.

NOTED

55. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE

(HAIRT)

A report of the Medical Director [Board Paper No. 17/28] asked the Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Armstrong explained that the report represented data on the performance of NHSGGC on a range of key HAI indicators at national and individual hospital site level and led the NHS Board through a summary of performance particularly in relation to:-

- Staphylococcus Aureus Bacteraemias (SABs);
- Clodistrium Difficile (C.Diff);

Dr Armstrong noted that the report of the national HAI and Antimicrobial Prescribing Point Prevalence Survey 2016 had indicated an overall HAI rate of 3.1% for NHSGGC acute hospitals, which was a reduction from 2011 rates and below the 2016 national rate of 4.6%. All hospitals in NHSGGC were below the national prevalence rate.

Dr McGuire outlined that two unannounced Healthcare Environment (HEI) / Healthcare Improvement Scotland (HIS) inspections had taken place in Stobhill Ambulatory Care Hospital and in Glasgow Royal Infirmary, and the reports were not yet available. Work continued with all staff to ensure consistency across sites and a shared view of accountability.

NOTED

56. PATIENT EXPERIENCE REPORT – 1 OCTOBER 2016 TO 31 MARCH 2017

A paper of the Nurse Director [Board Paper No. 17/29] asked the NHS Board to note the report on Patient Experience in NHSGGC for the period 1 October 2016 until 31 March 2017.

Dr McGuire led Members through the report highlighting the methods used to highlight the opportunities to bring about service improvements for patients through Complaints received, SPSO Investigation reports and Decision Letters, feedback opportunities and Patient Advice and Support Services activities. She highlighted the key themes raised in complaints in particular relating to clinical care as well as communication and staff attitude and behaviour.

Ms McAuley noted the helpful nature of this report and that it was useful to review the themes highlighted with an overview at strategic level.

NOTED

57. MEETING THE REQUIREMENT OF EQUALITY LEGISLATION : A FAIRER NHSGGC PROGRESS REPORT

A report of the Head of Equality & Human Rights [Board Paper No. 17/30] asked the NHS Board to note the areas of progress and new areas for development in 2017/18.

Ms Erdman summarised the report for members and highlighted the key issues to be

considered. Ms Erdman described the range of work underway across NHSGGC to meet the mainstreaming and equality actions set at the beginning of 2016. Following on from this, in 2017/18 there were additional priorities driven by new legislation and the Public Sector Equality Duty set out in the Equality Act 2010 including ensuring NHSGGC Equality Impact assess financial decisions and service changes; publishing equal pay statement and fulfilling requirement of new duties relevant to equality and human rights.

Mr Brown thanked Ms Erdman for a very helpful report and commended the team work evidenced to produce the report.

Dr Lyons noted the work carried out in relation to reminding staff working with interpreters to always focus on the patient in these circumstances. Ms Erdman agreed that this was a sensitive area and staff needed to remember to talk to the patient, not the interpreter.

NOTED

58. WEIGHT MANAGEMENT

A report of the Director of Public Health [Board Paper No. 17/32] asked the NHS Board to note the progress in embedding the community weight management service into the Glasgow and Clyde Weight Management Service and the establishment of multiple referral pathways.

Dr De Caestecker highlighted that the Community Weight Management Service had been fully operational for eight months using a commercial weight management provider. The evidence was that this was an efficient model and had demonstrated good results over this time period.

Mr Matthews commended this new promising approach, and queried whether even more investment would lead to even greater results. He also highlighted the correlation between obesity and GP attendance. Dr de Caestecker noted that capacity was not the main consideration in this way, rather the challenge presented in encouraging patients to attend a weight management service.

Ms McErlean noted the connection between weight reduction and health improvement and less reliance on medication.

Dr de Caestecker advised that there would be a full evaluation of the service and progress made, with main outcome reporting here being weight loss. There could be challenges in keeping in touch with patients who attended this service in order to complete a full evaluation. Ms Baxendale highlighted key conditions where weight loss could lead to a reduction in medication required e.g. liver disease.

Ms Forbes noted a similarity to preventative health care such as anti-smoking. Mr Ritchie acknowledged the importance of physical activity. Dr de Caestecker highlighted the amount of work carried out in HSCPs to communicate this message to patients, with work in schools and community based campaigns. Ms Brown noted the role legislation played in smoking and raised the need for this in food advertising and labelling.

The NHS Board had set up the Public Health Committee to review and highlight this

important area in the delivery of care. Mr Matthews, Chair of the Committee, highlighted that the Committee was cross system and involved with the HSCPs as well as acute services. Mr Williams re-affirmed this by noting the work carried out by colleagues in local authorities.

NOTED

59. RETAIL POLICY

A report of the Director for Public Health [Board Paper No. 17/33] asked the Board to note the successful implementation of the Healthcare Retail Standards and Healthy Living Award and to provide continued support to enable full implementation of the Food Retail policy.

Dr de Caestecker highlighted the robust nature of the policy which applied to all new retailers as well as to existing retailers as their lease came up for renewal. By the end of June 2017, NHSGGC would be almost 100% compliant with the policy with work continuing to reach this target.

NOTED

60. BOARD WORK PROGRAMME 2017/18

A report of the Head of Administration [Board Paper No. 17/34] asked the Board to approve the NHSGGC Board Work programme for 2017/18.

Mr Hamilton led Members through the background to this and the key recommendation that key activities be identified and brought together into the NHS Board Work Programme and, once approved, be managed as part of a structured programme delivered by the Executive Team with appropriate direction, support and oversight from the NHS Board. This would be a live document maintained by Mr Hamilton and fed back to the NHS Board.

Ms Grant underlined the need for the Corporate Objectives 2017/18 and the Board Work Programme to be integrated, with the intention being for the framework for this to be in place by October 2017. This would be progressed through the committee framework. Mr Brown added that this would give a clear pathway as to the channels through which work was being progressed and allow review of timescales as appropriate. **Chief Executive Officer**

Dr Lyons noted the number of committees had increased with an increase in the volume of papers issued and it would be helpful in future to highlight which papers had been scrutinised through the committee framework before coming to the NHS Board. **Head of Administration**

Mr Brown agreed that the focus would be on improving papers in terms of content. In September / October there would be a review of the effectiveness of Board governance arrangements as well as the demands made on Non – Executive Members. **Director of Human Resources & Organisational Development**

NOTED

61. AUDIT & RISK COMMITTEE MINUTES : 14 MARCH & 6 JUNE 2017

The Minutes of the meetings held on 14 March 2017 and 6 June 2017 [ACF(M)17/01 & A(M) 17/02] were noted.

NOTED

62. CLOSING REMARKS

The Board Chair wished to note that this would be the final Board Meeting for Mr K Redpath prior to his retirement, and to acknowledge the contribution Mr Redpath had made during his long and successful career with NHSGGC. Mr Brown expressed the NHS Board's gratitude for Mr Redpath's service and wished him well for the future.

Mr Brown also noted that Dr Cameron's term of office as a Non-Executive Board Member would come to an end on 30 June 2016. On behalf of the Board, Mr Brown thanked Dr Cameron for her significant contribution to the Board and for the dedication and commitment shown in three highlighted areas, namely, as chair of the Area Clinical Forum, as a Member of the Clinical & Care Governance Committee and West Dunbartonshire IJB.

On behalf of the Board, Mr Brown also took the opportunity to thank Mr J Legg for the valuable contribution he had made as a Board Member particularly as Chair of the Royal Hospital Children's Charity Forum, and the Board Champion for Cyber Security. Mr Legg had also been a Member of the Staff Governance Committee, Public Health Committee, Renfrewshire IJB and East Dunbartonshire IJB. Mr Brown wished Mr Legg well for the future.

NOTED

63. DATE & TIME OF NEXT MEETING

Tuesday 15 August 2017, 9.30am at The William Quarrier Conference Centre, 20 St Kenneth Drive, Govan, Glasgow G51 4QD.

The meeting ended at 2.25pm

BOARD OFFICIAL
DRAFT – TO BE RATIFIED

NHSGGC (M) 20/06
Minutes: 75 - 94

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
NHS Greater Glasgow and Clyde Board
held on Tuesday 27th October 2020, at 09:30am
via MS Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Cllr Caroline Bamforth
Ms Susan Brimelow OBE	Mr Alan Cowan
Cllr Jim Clocherty	Prof Linda de Caestecker
Ms Jacqueline Forbes	Ms Jane Grant
Cllr Mhairi Hunter	Ms Margaret Kerr
Ms Amina Khan	Mr Allan MacLeod
Mr John Matthews OBE	Cllr Jonathan McColl
Ms Dorothy McErlean	Dr Margaret McGuire
Cllr Sheila Mechan	Ms Ketki Miles
Ms Anne Marie Monaghan	Mr Ian Ritchie
Mr Francis Shennan	Ms Paula Speirs
Ms Rona Sweeney	Mrs Audrey Thompson
Mr Charles Vincent	Mr Mark White

IN ATTENDANCE

Ms Fiona Aitken	..	Royal College of Physicians of Edinburgh
Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Prof Michael Deighan	..	Royal College of Physicians of Edinburgh
Mr Graeme Forrester	..	Deputy Head of Corporate Governance and Administration
Mr David Leese	..	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 Service
Mrs Geraldine Mathew	..	Secretariat Manager (Minute)
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Julie Murray	..	Chief Officer, East Renfrewshire HSCP
Ms Catherine Ospedale	..	Deputy Director of Communications and Engagement
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
Prof Angela Wallace	..	Interim Executive Director of Infection Prevention and Control (For Item 89)

			ACTION BY
75.	**WELCOME AND APOLOGIES**		
	The Chair welcomed those present to the meeting. The meeting combined both members joining video conferencing and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were asked to		

	observe usual etiquette protocol, and presenters were asked to provide short presentations to highlight key points. Prof Brown was pleased to note that arrangements had been made to invite members of the public to observe the meeting and that some members of the public had joined the meeting via video conferencing. He noted that the arrangements put in place would continue for future meetings. Member apologies were intimated on behalf of Prof Dame Anna Dominiczak and Ms Flavia Tudoreanu. Officer apologies were intimated on behalf of Mr William Edwards, Director of eHealth. **NOTED**		
76.	**DECLARATIONS OF INTEREST**		
	Prof Brown invited members to declare any interests in any of the items being discussed. Mr Charles Vincent declared an interest in respect of Item 08 – Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update, and as such, would not participate in the discussion regarding this item. Mr Francis Shennan declared an interest in respect of Item 08 – Queen Elizabeth University Hospital (QEUH) and Royal Hospital for Children (RHC) Update, and as such, would not participate in the discussion regarding this item. The Board were content to note both declarations made. **NOTED**		
77.	**MINUTES OF PREVIOUS MEETINGS**		
a)	**MINUTE OF THE MEETING HELD 25TH AUGUST 2020**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 25th August 2020 [Paper No. NHSGGC (M) 20/04]. On the motion of Mrs Thompson, seconded by Mr MacLeod, the minute of the meeting was approved and accepted as an accurate record. In addition, discussion took place regarding Minute 62 - NHSGGC Remobilisation Plan Update. In respect of the approval of the NHSGGC Remobilisation Plan, Prof Brown confirmed that, as the NHS in Scotland remained under emergency measures due to the COVID-19 pandemic, the role of the Board would be to oversee the implementation of the Remobilisation Plan, as opposed to approval of the Plan that had already been approved by the Scottish Government. In respect of the final paragraph on page 12, regarding the consideration of the Moving Forward Together (MFT) Steering Group Terms of Reference and that this action required to be added to the Rolling Action List, following discussion, it was agreed that this action would be addressed as part of the Board		

	Development Plan work being led by Ms Vanhegan, Head of Corporate Governance and Administration. **APPROVED**		
b)	**MINUTE OF THE EXTRA-ORDINARY MEETING HELD 29TH SEPTEMBER 2020**		
	The Board considered the minute of the extra-ordinary meeting of NHS Greater Glasgow and Clyde Board Meeting held on Tuesday 29th September 2020 [Paper No. NHSGGC (M) 20/05]. On the motion of Ms Speirs, seconded by Ms McErlean, the minute of the meeting was approved and accepted as an accurate record. **APPROVED**		
78.	**MATTERS ARISING**		
a)	**ROLLING ACTION LIST**		
	The Board considered the Rolling Action List of the NHSGGC Board [Paper No. 20/49]. Members agreed to the closure of five actions from the Rolling Action List. In addition, the following matters were discussed: NHSGGC Board Meeting of 25th August 2020 [Paper No. NHSGGC(M) 20/04] - Minute 57, Chief Executives Report, Page 5, Paragraph 4 Mr Carr confirmed that, at present, there were no formal meetings of Integration Joint Boards (IJBs) and NHS Board Chairs, however he would shortly meet with the Chair of the IJB Chairs and Vice Chairs Group to discuss this further and would provide an update on the outcome of discussions, in due course. The Board were content to note the Rolling Action List and the updates provided. **NOTED**		
79.	**CHAIRS REPORT**		
	Prof 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 Audit and Risk Committee; Finance, Planning and Performance Committee; and the Public Health Committee. In addition, Prof Brown had attended a range of both local and national meetings, including the NHS Board Chairs Group and the NHS Scotland Corporate Governance Steering Group. Prof Brown provided an overview of a recent meeting with the Cabinet Secretary and discussions regarding key priorities for Boards including the Test and Protect Programme; and the Flu Immunisation Programme. He noted that the National Clinical Director of the Scottish Government had also provided the NHS Board Chairs Group with an update on the national strategic framework, with further updates expected in due course, and the Chief Executive of NHS Scotland had provided an overview of winter plans and the requirement to		

	ensure workforce plans were considered as part of this, not only to ensure that staff were supported throughout the winter period, but to ensure the necessary levels of resource was in place to maintain service levels. Prof Brown noted the work underway in respect of Active Governance, and Ms Kerr, who was leading on this work nationally, was asked to provide an update on progress to the Board, once this work had progressed. **NOTED**		**Ms Kerr**
80.	**CHIEF EXECUTIVES REPORT**		
	Ms Grant provided an overview of key elements of focus since the last meeting, including the ongoing response to COVID-19 in respect of the Test and Protect Programme; the Flu Immunisation Programme; the redesign of unscheduled care; and the remobilisation of services. Ms Grant had attended a number of important meetings including standing governance committees; the Test and Protect Programme National Group; the Strategic Advisory Group on Unscheduled Care Redesign; a session on Active Governance; a meeting with the Chair of the Public Inquiry into the QEUH and RHC; attendance at the recent Health and Sport Committee; a meeting with legal advisors in respect of the legal claim; meetings with the new Non-Executive Directors of the Board; and a meeting with Prof McQueen in respect of the work of the Oversight Board. Ms Grant added that MSPs and MPs were invited to attend a meeting with her and the Chair this week to provide an update on progress with the Flu Immunisation Programme. Prof Brown thanked Ms Grant for the update and invited comments and questions with regards to both the Chief Executive's update and the Chair's update. A question was raised in respect of Intensive Care Unit (ICU) beds within Inverclyde Royal Hospital (IRH) and recent media reports alleging the closure of the beds. Ms Grant confirmed that there were two ICU beds within the IRH and she confirmed that there were no plans to close the ICU beds at IRH and assured members that all patients across NHSGGC were cared for in the most appropriate setting to ensure the best treatment and outcomes. During the initial response to COVID-19, a number of patients were stabilised at the IRH ICU and then transferred to ensure optimal care and the best possible outcomes for patients. It was this clinical pathway that forms part of the Critical Care Network that had been misrepresented in the media. Dr Armstrong, Medical Director, went on to provide a background of the establishment of the Critical Care Network. She noted that the QEUH offered specialist advice and opinion in a range of modalities. Clinicians at IRH ICU had developed close working relationships with the specialists based at QEUH whereby clinicians could call the direct number for advice and support directly from QEUH colleagues. There was no intention of closing the ICU beds at IRH and she noted that it was appropriate that patients were transferred to receive specialist treatment, where clinically necessary. She added that, during the initial response to COVID-19, additional experienced doctors were deployed to IRH to provide support to the service.		

	Mr Best, Chief Operating Officer, confirmed that the 2 beds within IRH ICU were level 3 beds, which treated approximately 1450 patients in the previous year across the critical care floor, and less than 100 of those patients were stabilised at IRH ICU and transferred to QEUH for specialist treatment. He assured members that the organisation took into account the needs of the population of Inverclyde. In summary, the Board noted the position within Inverclyde, noted the overview provided by Ms Grant, Dr Armstrong and Mr Best, regarding the ongoing use of the ICU beds and the clinical pathways in place, and were assured that the clinical needs of the population of Inverclyde were taken into account, as was the case for the whole population of NHS Greater Glasgow and Clyde. **NOTED**		
81.	**PATIENT STORY**		
	Dr McGuire, Nurse Director, gave a presentation to members which provided an overview of the "Give and Go Volunteer Service" established in March 2020, during the initial response to the COVID-19 pandemic and the restricted visiting in hospitals as per national guidance, which was rolled out across all sites in April 2020. The presentation highlighted the positive difference the Service had made for patients, relatives and staff, which allowed family and friends to drop off personal items at a designated point in each site for delivery to the patient, with laundry collected from the patient and given to the relative or friend. The service dealt with approximately 2,000 bags per week across all hospital sites and has been extremely well received and appreciated by patients, staff, and patients' family and friends. Prof Brown thanked Dr McGuire for the update. He commended the work of the service and volunteers for ensuring that patients received support during this difficult time and intended to write to the Coordinator of the service to express the gratitude of the Board to all staff and volunteers involved for making such a positive difference for patients and staff. **NOTED**		
82.	**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. 20/50] presented by Ms Jane Grant, Chief Executive. The paper provided an overview of progress in respect of the various issues regarding the QEUH and RHC. Ms Grant provided an overview of key work streams including the work of the Oversight Boards in respect of Communications and Engagement; and Infection Prevention and Control. She noted the indicative timescales associated with the final reports of these Oversight Boards, and highlighted that the Case Note Review remained ongoing, in addition to estates work in respect of Ward 2a and 2b at RHC; the legal proceedings underway; and the work to implement the recommendations made by the Independent Review of QEUH and RHC.		

	Prof Brown thanked Ms Grant for the update and invited comments and questions from members. In response to a question regarding oversight and timescales in respect of the implementation of the recommendations made by the Independent Review, Ms Grant anticipated that this would be presented to the Finance, Planning and Performance Committee in December 2020, and onwards to the Board Meeting in December 2020. A question was raised regarding the status of the Oversight Board reports and if these would be presented to the Board. Ms Grant highlighted that, as the Oversight Boards were commissioned by the Scottish Government, the reports would be approved by the Scottish Government, and any presentation of such to the Board would be for information purposes. In response to a question regarding the Public Inquiry Oversight Executive Group reporting mechanisms, Ms Grant confirmed that progress would be reported regularly to the Finance, Planning and Performance Committee. In summary, the Board were content to note the current position in respect of the escalation to Level Four of the NHS Scotland Performance Management Framework; the position regarding the recommendations of the Independent QEUH Report; the Public Inquiry into the Royal Hospital for Children and Young People in Edinburgh and the QEUH Campus; the position in relation to the pursuit of legal action for loss and damages in relation to the QEUH and RHC; and the work being progressed by the Board regarding the Health and Safety Executive investigation. The Board noted that the progress of implementation of the recommendations made by the Independent Review of QEUH and RHC; and the progress in respect of the Public Inquiry into the Royal Hospital for Children and Young People in Edinburgh and the QEUH Campus, would be reported to the Finance, Planning and Performance Committee, and then to the Board. The Board would anticipate updates in due course. **NOTED**		
83.	**NHSGGC REMOBILISATION PLAN UPDATE**		
	The Board considered the paper 'Remobilisation Plan – Progress Update' [Paper No. 20/51] presented by the Medical Director, Dr Jennifer Armstrong. The paper highlighted the progress achieved with remobilisation of health and care services during the COVID-19 pandemic. Dr Armstrong provided a presentation which covered a number of key elements which included the blueprint for transformation; background; public health priorities; planned care priorities; cancer care priorities; unscheduled care priorities; the West of Scotland Trauma Network; primary and community care; mental health; surge planning; and key issues. Prof Brown thanked Dr Armstrong for the update. He noted the comprehensive plan presented and the extensive work undertaken by the leadership team and all staff to develop this. He invited comments and questions from members. In response to a question raised regarding the ways in which health inequalities were being considered, Dr Armstrong confirmed that Equality Impact Assessments would be carried out on relevant aspects of the recovery plan. In		

addition, she noted that the Director of Communications and Engagement, Ms Sandra Bustillo, had been involved in development of work to gain the views and opinions of patients regarding the changes put in place due to COVID-19, and this would help inform longer term planning. Ms Bustillo provided an overview of this work which included three strands of evaluation work and would consider the implementation of "Near Me"; work with patients whose first language was not English; and the service changes implemented in respect of the GP Out of Hours Service. Prof de Caestecker, Director of Public Health, added that it was vital the organisation ensured that actions taken contributed to reducing health inequalities, and a range of areas were being considered including digital inclusion; employability; and poverty. She confirmed that updates on these areas of work would follow in due course.

A question was raised regarding the effectiveness of the Test and Protect Programme, if there was any data regarding follow up of contacts, and if individuals were complying with self-isolation requirements. Prof de Caestecker provided an overview of the process in respect of the Test and Protect Programme. She noted the range of testing facilities available including walk-through and drive-through testing. Every effort was made by Test and Protect staff to get in touch with contacts quickly, and appropriate advice given regarding self-isolation guidance. She noted that there was growing data in respect of compliance with self-isolation, however this was a matter for national consideration. She assured members that work continued with Local Authority colleagues to support the most vulnerable groups of the community who need additional support to self-isolate.

In response to a question regarding an increase in activity within GP Out of Hours Service and if this was a particular concern as winter approached, Ms Millar assured members that work continued across NHSGGC with HSCP colleagues, GP and Primary Care colleagues, to ensure a balance of remobilisation of services in the context of the quickly changing COVID-19 environment. She highlighted the implementation of virtual consultations; the ongoing infection prevention and control requirements within GP practices and cognisance of further surge of COVID-19.

A question was raised regarding the GP Out of Hours Service changes and if the changes made were sufficient in addressing the challenges raised under escalation. Ms Grant provided an overview of the current position. She highlighted that updates on progress were provided to Finance, Planning and Performance Committee regularly. She noted work was ongoing in respect of the Clyde arrangements, with GP colleagues fully involved in development of ways to augment the service there. Near Me had been implemented for use within the service, and a meeting with Sir Lewis Ritchie had recently taken place to provide an update on progress, with plans in place for an additional meeting. The organisation was in the process of engagement to build a multi-disciplinary workforce and overall, the service remained in a reasonable position.

In response to a question regarding the sustainability of the changes in the longer term, Mr White clarified that many of the models were under development, therefore the financial position remained inconclusive. Furthermore, discussions with Scottish Government colleagues remained ongoing in respect of the financial settlement for the financial year, however further information would be available by the Board Meeting in December 2020.

	A question was raised regarding the significant pressure on staff over the past months, and, whilst a focus on staff wellbeing was welcomed, concerns were raised regarding how this would be managed moving towards the winter period and additional COVID-19 surges. Ms Grant confirmed that the wellbeing of staff remained an important priority, particularly over the coming winter months. She acknowledged that staff had tackled significant challenges and additional challenges lay ahead in the coming months in respect of winter, COVID-19 and the remobilisation of elective care. She assured members that this would be monitored closely over the coming months and actions would be taken to address this where required. Mr Best added that a significant amount of work had been undertaken to address the ongoing challenges. He noted that additional weekend sessions had been implemented, along with work with the Golden Jubilee National Hospital (GJNH), and establishment of outpatients within the NHS Louisa Jordan hospital, with the aim of ensuring a balance between response to the ongoing challenges associated with COVID-19, winter priorities, and elective care. Mrs MacPherson, Director of Human Resources and Organisational Development, highlighted a number of key areas of work in respect of staff wellbeing. She noted the implementation of the Mental Health Wellbeing Plan and the increase in provision of counselling services, Cognitive Behavioural Therapy (CBT) and psychological therapies. She highlighted that over 400 staff have accessed additional support. She assured members that the key messages remained listening, supporting, and encouraging managers to provide coaching in a wellbeing focused environment. She noted that a formal proposal would be developed and presented to Corporate Management Team in due course in respect of clinical and peer support. All staff were encouraged to ensure appropriate rest periods and the use of annual leave. In addition, resilience programmes were under development, led by the Organisational Development Team. Ms McErlean added that Staff Side colleagues had been very supportive throughout this period and staff had demonstrated commitment and flexibility throughout this difficult period. In response to a comment regarding reported problems with the roll out of digital ways of working and equipment to support this, Ms Grant commended the Director of eHealth, Mr William Edwards and the eHealth Team for undertaking a significant amount of work to implement equipment and new ways of working swiftly. She urged members to report any specific issues to Mr Edwards to ensure that the eHealth Team address this quickly. A question was raised regarding the current challenges and the plans in place to both “dial up” or “dial down” services to address surges associated with COVID-19, and what consideration was being given to shielding, self-isolation, and future scenario modelling. Ms Grant was cognisant of the current challenges and assured members that the Strategic Executive Group (SEG) continued to meet three times per week to address these, therefore there was continual review of the position and the actions required to address this taken, to both reflect the local and national picture. Given that NHS Scotland was currently under emergency powers due to the ongoing COVID-19 pandemic, a question was raised about the ways in which the public would be consulted with in respect of changes implemented. Prof Brown advised that Scottish Government colleagues were in the process of developing national guidance on how NHS Boards should be engaging with the		

	public, at this time. He noted that a presentation would be provided at the next Corporate Governance Steering Group meeting in December to describe the approach. In summary, the Board were content to note the Remobilisation Plan submitted to the Scottish Government on 31st July 2020, and note the progress in remobilising services in the key priority areas. The Board anticipated fuller briefings on progress of remobilisation to Finance, Planning and Performance Committee, with brief updates to Board meetings, in due course. **NOTED**		
84.	**COVID-19 AND WINTER PRIORITIES**		
	The Board considered the paper 'COVID-19 Update' [Paper No. 20/52] presented by the Director of Public Health, Prof Linda de Caestecker. The paper provided an overview of the overall position in respect of the NHSGGC response to manage COVID-19. Prof de Caestecker noted that, whilst overall there was increasing incidence in infection, she noted a reduction in infections on the previous day, which was reflective of the current restrictions having a positive impact on transmission. She noted incidence in infection amongst specific population groups including the younger age groups; and the working age population. Discussions with Scottish Government advisors remained ongoing in respect of the level of infections and appropriate restriction level. Prof de Caestecker highlighted the meeting held with MP and MSP colleagues in respect of the ongoing flu immunisation programme and the vaccination of older people. Prof de Caestecker noted that the flu season inclined to commence in December of each year and assured members that all eligible groups, including the older population, would be invited for vaccination prior to this. Mr Best went on to provide an overview of the current position as it related to Acute Services. He noted that a significant amount of learning had been gained following the first surge of infections and this had informed the approach for the second surge. He noted that there had not been as sharp an increase in the number of patients requiring admission to ICU, therefore there were less patients in ICU but more patients in High Dependency Units, than in the first wave. However, the most significant impact currently was in respect of the closure of wards due to COVID-19 and staff requiring to self-isolate. He noted that there were currently more inpatients with COVID-19, than that of the peak of the first wave, however it was anticipated that this would begin to level off as the winter period approached. Prof Brown thanked Prof de Caestecker and Mr Best for the update and invited comments and questions from members. A question was raised regarding the recent communication about the flu immunisation programme, and it was felt that an overview of the current position would be useful. Additionally, it was suggested that, when circulating communications to Board members, that a background of the position be included. Prof Brown provided an overview of the background to this issue, which had resulted in concerns being raised about the arrangements for the older population to receive the flu vaccination. Prof Brown assured members		

that, whilst the concerns had been addressed fully, there was no risk given that the flu season had not yet commenced and assurances had been given that older people would be invited for vaccination by the start of the flu season. He did acknowledge the points raised regarding communications, and it was highlighted that these concerns provided useful learning, particularly in respect of planning for a future COVID-19 vaccination programme.

In response to a question regarding the staff flu vaccination programme, the number of staff vaccinated to date and if this represented an increase on uptake in the previous year, Prof de Caestecker confirmed that over 11,000 staff had been vaccinated to date, with a further 8,000 staff registered to attend a flu vaccination appointment. This represented a higher uptake than that of the previous year at this point.

A question was raised about work undertaken to model the likely impact of flu this season, given the social distancing measures in place. Prof de Caestecker advised that no specific modelling work had been done, however she noted that the southern hemisphere had experienced a much lighter flu season than that of previous years, therefore it was expected that there may be a positive impact of social distancing in respect of flu transmission. Additionally, it was important to note that there may also be an impact on flu cases from the effect of a more virulent virus in circulation.

In response to a question regarding the number of delayed discharges and whether there was potential to open additional beds for winter, Mr Best assured members that COVID-19 beds were planned alongside winter beds. He noted that a number of winter wards had been identified for use in December and January, and the position in respect of COVID-19 would continue to be monitored collectively with the need for additional winter beds. Dr McGuire, Nurse Director, added that some care homes were closed to admissions due to COVID-19, and this had resulted in an impact on delayed discharges. In addition, there were pressures in respect of the Equalities and Human Rights Commission (EHRC) legal challenge and Adults with Incapacity. She assured members that work continued with HSCP colleagues, to not only avoid admissions, but to reduce the number of delayed discharges, where possible. Ms Millar highlighted that the pressures experienced in the Acute Sector, were mirrored within community services. She highlighted the impact on staff during this second wave of COVID-19, and the number of care homes currently closed to admissions. She assured members that consideration was being given to manage the approach to closures. She confirmed that arranging suitable accommodation for AWI outside of the acute hospitals continued to be a challenge.

A question was raised about the management of the Corporate Risk Register and the COVID-19 risks. Mr White confirmed that both risk registers were being merged and risks reviewed to reflect COVID-19 implications. Both the Corporate Risk Register and the COVID-19 Risk Register would be presented to the Audit and Risk Committee in December 2020.

In response to a question about the potential to change the Ambulatory Care Hospitals (ACH) – Stobhill and Victoria, to extend past 23 hours, Ms Grant confirmed that this had been an option that was given consideration. She assured members that the organisation was actively considering how to ensure the continuation of as much elective care as possible, whilst ensuring this was reduced within main sites. Mr Best added that there was medical cover available

	at the ACH's, and activity took place Monday to Thursday, with additionality at weekends. He assured members that consideration was being given to maximising the potential of the ACHs moving forward, to support elective care. In summary, the Board were content to note the report, and a number of key issues described including current COVID-19 activity within hospitals; Acute and HSCP updates; the position in respect of care homes; the Test and Protect Programme; Remobilisation; and surge planning. The Board would anticipate further updates in due course. **NOTED**		
85.	**NHSGGC PERFORMANCE UPDATE**		
	The Board considered the paper 'Board Performance Summary Report' [Paper No. 20/53] presented by Mr Mark White, Director of Finance. The paper provided an overview of the current performance position across NHSGGC in relation to a number of high level key performance indicators. Mr White highlighted the key elements of the report including the change in format of the report to reflect the remobilisation plan trajectories and targets which had necessitated a change in style of the report. He noted the ongoing focus on activity, to return to pre-COVID-19 performance, highlighted the new suite of measures which focused on this and emphasised the summary position for Quarter 2 – July 2020 to September 2020. Prof Brown thanked Mr White for the update and invited comments and questions from members. In response to a question about the new trajectories, whether these were explicitly detailed within the Remobilisation Plan, and the governance process for reporting of these trajectories, Mr White highlighted that these were detailed within page 139 of the Remobilisation Plan. He confirmed that the key performance indicators would be presented to the Acute Services Committee for scrutiny, along with the Finance, Planning and Performance Committee. A question was raised regarding the increasing presentations at Emergency Departments, the reasons for this, and if the redirection activities were sufficient to address this. Mr Best highlighted the positive work undertaken within EDs to bring forward changes in respect of this. He noted the signposting approach being taken and that this was working well. The increased levels in presentations were likely related to people who would have previously presented at ED, but had not done so due to previous lockdown measures, returning. Mr Best described a range of work with colleagues, the establishment of the Community Assessment Centres (CACs) for COVID-19, the Specialist Assessment and Treatment Areas (SATAs), GP Assessment Units and the work of the Minor Injuries Unit, to tackle this and to ensure patients were treated in the right place, at the right time, without having to be redirected. Furthermore, Dr Armstrong described work ongoing nationally to develop an approach to redirection and an announcement by the Scottish Government was awaited, as part of the urgent care redesign work. Nevertheless, there remained a number of areas of work being pursued locally to ensure that patients were directed to the most appropriate service at the right time.		

	In response to a question about the KSF/PDP performance and whether this had been paused due to COVID-19, Mrs MacPherson confirmed that, whilst this had not been paused, there had been a reduction in the number conducted, however there was currently no active monitoring in this area. She was clear that the organisation remained committed to the development of staff and KSF/PDP formed a key component of this, as it provided an opportunity for managers to meet with staff and discuss opportunities. Mrs MacPherson noted that iMatter had been paused this year due to COVID-19, however a staff survey had been undertaken. She assured members that these key areas of work would be refreshed in due course. In summary, the Board were content to note the current performance position against each of the measures outlined in the draft second-phase Remobilisation Plan and the proposed improvement actions for those areas in need of improvement. **NOTED**		
86.	**NHSGGC FINANCE UPDATE**		
	The Board considered the paper 'Finance Report – Month 5' [Paper No. 20/55] presented by the Director of Finance, Mr Mark White. The report provided the Month 5 financial position, including the progress and position of the Financial Improvement Programme (FIP). The report also included information on the additional expenditure incurred as a result of COVID-19, planned expenditure as part of Remobilisation and the negotiations with the Scottish Government about a corresponding financial statement. Mr White noted that, in Month 5, the organisation reported an overspend of just under £102m. This comprised of £66m of direct COVID-19 costs, and £36m attributed to unachieved savings. The Scottish Government had outlined the revised reporting process and a detailed submission was returned in September 2020. Mr White described the model used to allocate COVID-19 funding to NHS Boards, which resulted in NHSGGC being allocated £169m, which represented £102m for the Board, and £67m for HSCPs. Negotiation continued in respect of future allocations and Mr White highlighted that discussions with Scottish Government colleagues had been positive. Mr White described the likely position moving forward, and noted that, should NHSGGC receive the full requested amount, the organisation would likely breakeven, at 31st March 2021. Prof Brown thanked Mr White for the update and invited comments and questions from members. In response to a question raised regarding page 10 of the report and the four key areas highlighted, those being; NRAC; winter pressures; remobilisation; and unachieved savings, and the likelihood of these areas being financed in full by Scottish Government, Mr White highlighted that the Scottish Government were very supportive of the position, and he remained reasonably confident, however there remained a risk. He anticipated that there would be a greater understanding of the position by the December 2020 Board meeting. He emphasised that there would also be a requirement to consider the financial position for 2021/22 and the position in respect of sustainability.		

	A question was raised regarding the Financial Improvement Programme and the likelihood of achieving the objectives of the programme in the second part of the year. Mr White remained optimistic and assured members that there were a number of key areas, not related to staffing, in which work could be undertaken to ensure efficiency. Whilst he acknowledged that this would be challenging, he emphasised the need to ensure that efficiency was the hallmark of everything we do. In summary, the Board were content to note the revenue position at Month 5 and the initial financial settlement position; note the Month 5 position with the FIP; and note the capital position at Month 5. The Board would anticipate a further update on further financial settlements, the financial outlook, and sustainability, at the next meeting in December 2020. **NOTED**		**Mr White**
87.	**COMMUNICATIONS AND ENGAGEMENT STRATEGY**		
	The Board considered the paper 'Draft Stakeholder Communications and Engagement Strategy' [Paper No.20/56] presented by Ms Sandra Bustillo, Director of Communications and Engagement. The paper set out the draft strategy to deliver a planned and sustained approach to communications and engagement which aimed to build collaborative, trusted relationships between the Board, our patients, their carers, and our communities, based on honesty, openness and transparency. Ms Bustillo provided a presentation which covered the key elements. She provided an overview of the context of the Strategy including COVID-19; Moving Forward Together; HSCP Strategic Plans; Quality Strategy; QEUH and RHC' and Turning the Tide Through Prevention. In addition, Ms Bustillo outlined the strategic aims; stakeholder mapping and sentiment analysis; communications; engagement; and reputation. Prof Brown thanked Ms Bustillo for the update and invited comments and questions from members. Members commended the report and presentation, which described clearly the outcomes and strategic aims, and noted the proposal to develop an Annual Delivery Plan. In response to a question regarding clinical engagement and the role of the Area Clinical Forum, Ms Bustillo recognised that there was wider consultation and engagement with staff and this was incorporated into a separate strategy which was routinely presented to the Area Partnership Forum and Area Clinical Forum for consultation and contribution. A question was raised regarding the Annual Delivery Plan and the timescales for completion. Ms Bustillo stated that this would be developed through the coming year, with review and approval via the Corporate Management Team, and the Finance, Planning and Performance Committee. In response to a question regarding the Remobilisation Plan, the service change within that, the need to ensure that the Strategy references this, Ms Bustillo		

	agreed that the Strategy should be more explicit in respect of the ongoing Remobilisation Plan. A question was raised regarding the Moving Forward Together Programme and clarity was sought regarding this, as members understood that this had been paused. Ms Bustillo clarified that, whilst the MFT programme had been paused, the themes and principles of the programme have continued to be delivered through Remobilisation Plan. In many respects, the themes and principles of the MFT programme had been implemented at a much greater pace. In response to a question regarding Equality Impact Assessments undertaken in respect of the new ways of working implemented during the response to the COVID-19 pandemic, Ms Bustillo advised that an Equality Impact Assessment (EQIA), sponsored by the Scottish Government, had been undertaken on a national basis on behalf of NHS Scotland, in respect of the Near Me Video Consulting Programme. Ms Bustillo agreed to circulate this to members for information. A question was raised regarding acknowledgement of when things could have gone better and the learning gained from these. Ms Bustillo stated that this was an important element and it was critical that learning from this was incorporated into development of plans. In response to a question regarding engagement with media colleagues and Editors, Ms Bustillo assured members that the Communications Team continued to work closely with media colleagues and Editors. The Team had developed strong relationships with a wide range of key colleagues within the media. She further assured members that the Team proactively respond timeously to refute and resolve any inaccurate reports. A question was raised regarding communications with Elected Members and it was suggested that contact be made with the Members Services Team within Local Authorities, to develop ways to improve engagement and communication with Elected Members. Ms Bustillo acknowledged that this was a useful suggestion. She highlighted that the Communications Team prepared weekly communications briefings for MPs and MSPs. In addition, Ms Bustillo highlighted that a report was prepared following each Board meeting which detailed the key areas discussed and this was also circulated to the IPN network, and papers from each Board meeting were publically available on the website. Mr Ritchie, Chair of the Stakeholder Reference Group (SRG) highlighted the crucial role of the SRG in respect of the Strategy. He stressed the importance of ensuring that consideration was given to those who may not have access to means of communicating and engaging digitally. In addition, Mr Ritchie was keen that consideration be given to including the process of communicating with patients on waiting lists for services that had been paused due to COVID-19. In summary, the Board were content to approve the Draft Communications and Engagement Strategy; the development of the Annual Development Plan; and recommended consideration be given to the following areas: • Remobilisation Plan • Clarity regarding MFT Programme • How the organisation responds when things have not gone as well as they could		**Ms Bustillo**

	• The organisations relationship with the media • Increasing communications with Elected Members via Member Services • Emphasis on ways in which communication and engagement would be undertaken, i.e. not solely digital methods The Board acknowledged the effort applied to develop the Strategy and would anticipate the next iteration of the Strategy at the December 2020 Board meeting, with an update on the Annual Development Plan to be presented to the Board in April 2021. **APPROVED**		**Ms Bustillo**
88.	**STRENGTHENING LEADERSHIP CAPACITY**		
	The Board considered the paper 'Update on Strengthening the Senior Management Team' [Paper No. 20/57] presented by the Chief Executive, Ms Jane Grant. The paper provided an update on the previously presented papers and described the overall position in respect of the changes to the Senior Management Team, as outlined in the February 2020 Board paper. Ms Grant provided an overview of the key areas augmented including Acute Division; GP Out of Hours; Communications and Engagement; Nursing and Allied Health Professionals (AHP) Directorate; Public Health; Finance; support for the Head of Corporate Governance and Administration and the Chief Executive; HR and Organisational Development; Moving Forward Together; Health and Social Care Partnerships; and Estates and Facilities. Prof Brown thanked Ms Grant for the update and invited comments and questions from members. In response to a question regarding the costs associated with the additional support, and authorisation of the posts, Ms Grant confirmed that none of the additional posts described required approval by the Remuneration Committee. In respect of the costs, Mr White agreed to compile these and include them within an overarching additional costs overview and it was agreed that a report would be presented to the Finance, Planning and Performance Committee. Furthermore, Mrs MacPherson confirmed that an overview of all senior management posts, whether they require Remuneration Committee approval or not, was provided at each meeting of the Committee. A question was raised regarding the maximisation of additional support and ensuring that this was enough to support the additional challenges. Ms Grant advised that this would be reviewed on an ongoing basis and arrangements made for additional support, if required. In response to a question regarding the balance between operational requirement and strategic requirement, and if this would be sufficient to support the Chief Executive, Ms Grant was keen to ensure that the Senior Management had sufficient time to focus on strategic requirements, and was confident that the additional resource to support operational aspects, would create capacity for the senior team to focus on strategic matters. However, Ms Grant assured members that this would continue to be monitored regularly. Prof Brown welcomed the report and was keen that this formed a regular update to the Board, and suggested that the next update be provided in April 2021.		**Mr White**

	In summary, the Board were content to note the update on the strengthening the senior management team. **NOTED**		
89.	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	The Board considered the paper 'Healthcare Associated Infection Report' [Paper No. 20/54] presented by the Interim Executive Director of Infection Prevention and Control, Prof Angela Wallace. Prof Wallace provided an overview of the key elements of the report, including the current pressures in respect of the ongoing response to COVID-19 and infection prevention and control measures. She noted steady performance in respect of Staphylococcus aureus bacteraemia (SAB), Clostridioides difficle infection (CDI), and Escherichia coli bacteraemia (ECB). Prof Wallace assured members that work continued across NHSGGC to ensure a high focus on reduction of infections. She highlighted that the report contained the individual Sector reports and the improvement activities in place. Prof Wallace confirmed that the number of COVID-19 presentation across all areas in NHSGGC were increasing, reflecting evident community transmission of COVID-19. These were reported within the Healthcare Associated Infection Report for September. She stated that the Infection Prevention and Control; Clinical; and Management Teams were working closely to respond to the pandemic. She continued by highlighting the outbreaks and incidents being managed at this time and were detailed within the report, including the areas of focus and the actions taken. Prof Brown thanked Prof Wallace for the update and invited comments and questions from members. In response to a comment about the inclusion of upper control limits, warning limits, and also the average, Prof Wallace explained that the average score was included in the report, as the numbers were small, therefore averages could help in understanding the position. She explained that the narrative that supported each data section was designed to explain the data and its significance in relation to the performance across the AOP standards. Prof Brown added that Ms Margaret Kerr was undertaking work nationally on Active Governance and this included how best to present data, therefore he was content for minor amendments to be made to the report, however, as there was other work underway nationally, and locally, he advised against any major overhauls of the reporting templates used. A question was raised regarding the action list contained within page 12 of the report which referenced contaminated blood culture receptacles, and how this issue was identified. Prof Wallace advised that this was a well-known national and international issue, and Prof Wallace highlighted that, although the numbers as highlighted in the report were extremely small, the improvement work noted on page 12 was designed to support and improve the reliability of taking blood cultures, reducing further contamination. A group of colleagues were taking forward this work and she explained to members that key actions were being taken as part of this work to support staff and provided training to minimise the occurrence of this. She further explained that the issue was identified through		

	continued review of individual care by clinical teams, infection control and laboratory staff. In response to a question regarding Prof Wallace's view of the functioning of the overall infection prevention and control system, Prof Wallace advised that she has provided consistent, clear feedback during her time as Interim Executive Director of Infection Prevention and Control. She assured members that she was fully supported by the Chief Executive, Senior Management Team, Infection Prevention and Control Team and clinical staff in respect of carrying out her responsibilities and throughout her time in this role, she has observed satisfactory management of infection prevention and control in NHSGGC. This led her to express the view that the current infection prevention and control systems across NHSGGC were of a standard that mitigated risks to an acceptable level. She explained that she continues to work with colleagues in moving services forward and to benchmark NHSGGC with other systems to capture learning including sharing good practice she has found in NHSGGC. She went on to describe a range of areas of work being taken forward to improve infection prevention and control designing a whole system improvement collaborative and the establishment of an infection control community leadership with Mr Tom Steele, Director of Estates and Facilities, as part of a Gold Command delivery system chaired by Ms Jane Grant, Chief Executive. In summary, the Board were content to note the Healthcare Associated Infection Report; note the performance in respect of the Annual Operational Plan (AOP) Standards for SAB; CDI and ECB; note the detailed activity in support of the prevention and control of Healthcare Associated Infection; and note contribution of the Infection Prevention and Control Team to NHSGGC recovery plans. The Board noted Prof Wallace's professional assessment and as a result were assured that the management of infection prevention and control was currently effective across NHSGGC and within the Board's risk appetite. The Board welcomed the work undertaken by Prof Wallace and the Infection Prevention and Control Team. **NOTED**		
90.	**GOVERNANCE ASSURANCE FRAMEWORK**		
	The Board considered the paper 'Governance Assurance Framework' [Paper No. 20/58] presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The paper provided an update on the development of the approach to Active Governance and the phases of development. Ms Vanhegan provided an overview of the key elements of the report including the focus on the Board Development Plan; the aims and values of the recrafted Corporate Objectives; the consideration of key corporate risks; and development of the assurance framework. Prof Brown thanked Ms Vanhegan and all those involved in the development of the work including Ms Kerr, Ms Mullen, and Dr Davidson. He invited comments and questions from members. In response to a question regarding how this would link into the processes described, Ms Kerr provided an overview of the current national work ongoing in respect of Active Governance. She advised that there were a number of aspects		

	being considered. In respect of performance measures, one set of indicators would not suit all Boards. She explained that work was ongoing to explore a number of areas including what type of information was required by Board members; what skills they would require; and what type of questioning would be useful, and a project was underway to look at these matters. In summary, the Board considered the phased approach to Active Governance in NHSGGC; noted the reaffirmed Board Purpose, Aims, Values and approved the recrafted Corporate Objectives and lead standing committee allocation; noted the further work to be undertaken in reviewing Corporate and Business Risks, Board Strategies which linked to the Corporate Objectives, and the development of the Information Assurance System reviewing targets and performance measures; and; noted the timescale for full implementation as April 2021. **APPROVED**		
91.	**PHARMACY PRACTICES COMMITTEE UPDATE**		
	Mr Matthews, Chair of the Pharmacy Practices Committee, provided an overview of the current position. He noted that the Committee had not met, and the Scottish Government was giving consideration to how the Committee could meet to fulfil its legislative obligations. **NOTED**		
91.	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**ACUTE SERVICES COMMITTEE**		
	The Board considered the paper 'Acute Services Committee Chairs Report' [Paper No. 20/60] presented by the Chair of the Acute Services Committee, Mr Ian Ritchie. The report provided an overview of the items discussed at the recent Committee meeting on 27th October 2020. The Board were content to note this. The Board considered the approved minute of the Acute Services Committee meeting of 21st July 2020 [Paper No. ASC (M) 20/02] and were content to note this. NOTED		
b)	**CLINICAL AND CARE GOVERNANCE COMMITTEE**		
	The Board considered the paper 'Clinical and Care Governance Committee Chairs Report' [Paper No. 20/61] presented by the Chair of the Clinical and Care Governance Committee, Ms Susan Brimelow. The report provided an overview of the items discussed at the recent Committee meeting on 15th October 2020. The Board were content to note this. The Board considered the approved minute of the Clinical and Care Governance Committee meeting of 3rd March 2020 [Paper No. CCG (M) 20/01] and were content to note this.		

	The Board considered the approved minute of the Clinical and Care Governance Committee meeting of 17th August 2020 [Paper No. CCG (M) 20/02] and were content to note this. **NOTED**		
c)	**AREA CLINICAL FORUM**		
	The Board considered the paper 'Area Clinical Forum Chairs Report' [Paper No. 20/62] presented by the Chair of the Area Clinical Forum, Mrs Audrey Thompson. The report provided an overview of the items discussed at the recent Committee meeting on 8th October 2020. The Board were content to note this. The Board considered the approved minute of the Area Clinical Forum meeting of 13th August 2020 [Paper No. ACF (M) 20/06] and were content to note this. **NOTED**		
d)	**FINANCE, PLANNING AND PERFORMANCE COMMITTEE**		
	The Board considered the paper 'Finance, Planning and Performance Committee Chairs Report' [Paper No. 20/63] presented by the Chair of the Finance, Planning and Performance Committee, Mr Simon Carr. The report provided an overview of the items discussed at the recent Committee meeting on 13th October 2020. The Board were content to note this. The Board considered the approved minute of the Finance, Planning and Performance Committee meeting of 11th August 2020 [Paper No. FPPC (M) 20/02] and were content to note this. The Board considered the approved minute of the Finance, Planning and Performance Committee special meeting of 15th September 2020 [Paper No. FPPC (M) 20/03] and were content to note this. **NOTED**		
92.	**NHSGGC BOARD AND GOVERNANCE COMMITTEE CALENDAR 2021/22**		
	The Board considered the paper 'NHSGGC Board and Governance Committee Calendar 2021/22' [Paper No. 20/64] presented by Ms Elaine Vanhegan, Head of Corporate Governance and Administration. The Board were content to adopt the calendar of dates for NHSGGC Board and Governance Committees, as presented. **NOTED**		
93.	**AOCB**		
	Valedictory		

	Prof Brown informed members that Mr David Leese, Chief Officer of Renfrewshire HSCP, had resigned from his post and would shortly leave the organisation to take up a post out with the public sector. Mr Leese had had a long career with NHSGGC. He joined the organisation in 1993 and had been Chief Officer of Renfrewshire HSCP since 2015. Over that time, Mr Leese had made a significant contribution to the NHS and to the HSCP. Prof Brown thanked Mr Leese for his commitment over a number of years. He wished Mr Leese well on behalf of the Board, for his future endeavours, and noted that Mr Leese would be greatly missed by a significant number of colleagues. Mr Leese noted his thanks to a number of colleagues including Board members, IJB colleagues, and the wider teams, for their support throughout his career.		
94.	**DATE OF NEXT MEETING**		
	Tuesday 22nd December, 09:30am, MS Teams		

BOARD OFFICIAL
DRAFT – TO BE RATIFIED

NHSGGC (M) 20/07
MINUTES: 95 – 110

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
NHS Greater Glasgow and Clyde Board
Held on Tuesday 22nd December 2020, at 09:30
Via MS Teams

PRESENT:

Mr John Matthews OBE (in the Chair)

Dr Jennifer Armstrong	Cllr Jonathan McColl
Cllr Caroline Bamforth	Ms Dorothy McErlean
Ms Susan Brimelow OBE	Cllr Sheila Mechan
Mr Simon Carr	Ms Anne Marie Monaghan
Cllr Jim Clocherty	Cllr Iain Nicolson
Mr Alan Cowan	Mr Ian Ritchie
Prof Linda de Caestecker	Mr Francis Shennan
Ms Jacqueline Forbes	Ms Rona Sweeney
Ms Jane Grant	Ms Paula Speirs
Cllr Mhairi Hunter	Ms Audrey Thomson
Ms Margaret Kerr	Ms Flavia Tudoreanu
Ms Ketki Miles	Mr Charles Vincent
Ms Amina Khan	Mr Mark White
Mr Allan MacLeod	

IN ATTENDANCE:

Mr Callum Alexander	..	UCC Planning and Implementation Support Manager
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
Ms Jennifer Haynes	..	Corporate Services Manager – Governance (minute)
Ms Lorna Kelly	..	Interim Director of Primary Care
Ms Anne MacPherson	..	Director of Human Resources and Organisational Development
Ms Susanne Millar	..	Chief Officer, Glasgow City HSCP
Ms Louise Russell	..	Secretariat Officer (minute)
Mr Tom Steele	..	Director of Estates and Facilities
Ms Shiona Strachan	..	Interim Director of Renfrewshire HSCP
Ms Elaine Vanhegan	..	Head of Administration and Corporate Governance
Prof Angela Wallace	..	Interim Executive Director of Infection Prevention and Control (item 10)

			ACTION BY
95	**WELCOME AND APOLOGIES**		
	Mr John Matthews welcomed those present to the meeting, and explained that he was chairing in the absence of the Board Chair, Prof John Brown. The meeting combined members joining via video conferencing, and a socially distanced gathering of some members within the Boardroom of JB Russell House. Mr Matthews reminded everyone that the meeting was public, and asked members to keep presentations succinct, as everyone had received and had an opportunity to review papers in advance. Member apologies were intimated on behalf of Prof Brown and Prof Dame Anna Dominiczak. Officer apologies were intimated on behalf of Ms Julie Murray, Chief Officer for East Renfrewshire HSCP. **NOTED**		
96	**DECLARATIONS OF INTEREST**		
	Mr Matthews invited members to declare any interests in any of the items being discussed. Mr Matthews also reminded members of the requirement to keep their details on the register of interest up to date, and notify Ms Elaine Vanhegan, Head of Administration and Corporate Governance, of any changes. Mr Francis Shennan noted that he was in receipt of a gift from Multiplex in March 2020, which he had previously declared. **NOTED**		
97	**MINUTES OF PREVIOUS MEETING**		
a)	**MINUTE OF THE MEETING HELD 27TH OCTOBER 2020**		
	The Board considered the minute of the NHS Greater Glasgow and Clyde Board Meeting held on 27th October 2020 [Paper No. NHSGGC (M) 20/06]. On the motion of Ms Paula Speirs, seconded by Ms Jacqueline Forbes, the minute of the meeting was approved and accepted as an accurate record. **APPROVED**		
98	**MATTERS ARISING**		
a)	**BOARD ROLLING ACTION LIST**		
	The Board noted the Rolling Action List of the NHSGGC Board [Paper No. 20/65] **NOTED**		

99	**CHAIR'S REPORT**		
	Mr Matthews confirmed that he had spoken to Prof Brown, who confirmed that he would provide a report at the next meeting of the Board. **NOTED**		
100	**CHIEF EXECUTIVE'S REPORT**		
	Ms Grant confirmed that she would provide an overview of key issues since the last meeting, which would also cover some of what Prof Brown had planned to convey. Ms Grant noted that COVID-19 remained a significant challenge, coupled with routine winter pressures, and the redesign of unscheduled care. The Annual Review of NHSGGC had also taken place at the start of December 2020, and the Interim Report for the QEUH / NHSGGC Oversight Board (the Interim Report) had been published on 21 December 2020. With regards to COVID-19, Ms Grant noted there had been a lot of activity around test and protect, as well as mass testing for both patients and staff, which required a high degree of orchestration. A new regional laboratory for the West, being operationally managed by NHSGGC, was opened on 12 December 2020, and the Cabinet Secretary visited that day, which had been a positive visit. Ms Grant noted that that winter planning was well underway, the flu vaccination programme was almost complete, and that there was a focus on roll out of the COVID-19 vaccination programme, with vaccinations for care home residents and HSCP staff already underway. A new model for unscheduled care had a soft launch on 1 December 2020, with patients phoning 111 before attending Emergency Departments. Initial results were encouraging. Work on the GP Out of Hours Service continued, and it was hoped in the New Year this will be a fuller service. Ms Grant noted a number of senior appointments, including: Shiona Strachan as Interim Chief Officer for Renfrewshire HSCP; Melanie McColgan as Director for Clyde Sector; Ms Jackie Carrigan and Fiona McEwan as Assistant Directors of Finance; Lorna Kelly as Interim Director of Primary Care and; Geraldine Jordon as Head of Clinical Governance. Ms Grant noted the ongoing work regarding the legal claim with regards to the QEUH, and confirmed that this would be discussed in more detail at a private Board session on 19 January 2021. In terms of the Interim Report, Ms Grant confirmed that the recommendations would be addressed in a positive and constructive manner, and indeed some actions were already well underway. A final report was likely in early 2021, as was the Case Note Review outcome. Ms Grant noted a significant increase in drug deaths, which had been widely reported in the media. Professor Linda de Caestecker, Director of Public Health, confirmed that data published on 15 December 2020		

	reported an increase of 6.5% in Scotland compared to last year, with an increase of 2.5% in NHSGGC. In the Glasgow City Council boundary there was a small reduction, for the first time since 2013. The rate of change was variable in different HSCP areas, drug deaths were more prominent in males, and affected the age 45-54 age range most. Prof de Caestecker noted that this issue was an important contributor to the stalling of life expectancy. Alcohol and Drug Partnerships were looking at the data in detail, and considering strategies to deal with the issue. Prof de Caestecker noted that this required to be a cross agency approach, with a safe drug service, and access to rehabilitation services. Ms Grant also acknowledged the recent media coverage with regards to building cladding at the QEUH site, as a result of the issues identified in the Grenfell Public Inquiry. Mr Tom Steele, Director of Estates and Facilities, noted that we had been following all appropriate advice and guidance, had written to Multiplex to establish product quality, and, in the meantime, had undertaken a local investigation. We await a formal response from Multiplex. Ms Grant gave feedback on the Annual Review, noting that she and the Chairman had both considered it positive and constructive. Ms Grant reported that there was recognition of progress and improvement in some key areas. Mr Matthews thanked Ms Grant. **NOTED**		
101	**PATIENT STORY**		
	Dr Margaret McGuire, Nurse Director, gave a presentation to members which provided an overview of 'Attend Anywhere' and virtual appointments for patients, noting that since March 2020, there had been 116,617 virtual appointments across Acute Services, Mental Health and Primary Care. An optional evaluation survey had shown positive feedback; patients reported that they did not feel it was an issue not being in the same room as their clinician, many found it preferable to physically having to attend an appointment, and others felt it was more efficient for staff. Carers also reported positively about virtual appointments, noting that it was especially useful for those who were anxious about leaving their home. In terms of learning, Dr McGuire commented that there had been an assumption that older people may not like it, but that was not the case. Dr McGuire invited Ms Sandra Bustillo, Director of Communication and Engagement, to comment, and Ms Bustillo noted that although there were significant benefits, it was not a 'one size fits all' model, and that it was not appropriate to completely move to that model, as there were still times when a face to face consultation was most appropriate. There were also vulnerable groups – for example, as a result of domestic abuse – where there was not a safe space at home to participate, and so face to face consultations with a clinician were more appropriate.		

	The learning had been shared with Virtual Patient Management Group, which was considering how to adapt the use of technology based on the feedback. The learning had also been shared learning with the front facing services. Ms Bustillo confirmed that they were looking at ways to promote the usage, to encourage future patient to feel comfortable. Dr McGuire noted that the success of the programme was testament to both patients and the eHealth team to embracing its usage. Mr Matthews thanked Dr McGuire and Ms Bustillo, noting that one of the few positives of the COVID-19 position was the opportunity to embed new and innovative ways of working, such as this. Mr Alan Cowan commented on whether those from areas of deprivation would have the same access to this service as others from more affluent areas, in terms of devices and training, and asked if consideration had been given to ensuring equity of access. Dr McGuire confirmed this was something that had been considered, and Mr William Edwards, Director of eHealth, elaborated further, explaining that all appointments were booked by the Referral Management Centre, and before a consultation was arranged, patients were given a choice of face-to-face or virtual appointments. The technology also runs on mobile phones, and some consultations were also undertaken by telephone call. There was therefore a blended approach to suit all patients. Ms Ann Marie Monaghan noted that from another piece of work she was involved with, she was aware of significant work nationally to support individuals get on line, including providing computer hardware, to help address inequalities. Ms Speirs asked about the dependence on public WiFi, and Dr McGuire confirmed that had also been taken into consideration, with solutions in place. **NOTED**		
102	**COVID-19 AND WINTER PRIORITIES**		
	The Board considered the paper 'COVID-19 and Winter Pressures' (Paper No. 20/66) presented by Prof de Caestecker. Prof de Caestecker confirmed that the numbers of COVID-19 positive cases had been declining slowly, but had increased in recent days, with the rate currently at 135 per 100,000. The estimated dissemination (local R number) had remained consistently below 1, and was now at 0.98 in NHSGGC as a whole, but over 1 in West Dunbartonshire and Inverclyde. Outbreaks remained consistent in terms of location, which tended to be in, for example, care homes and schools. Prof de Caestecker commented on the expansion of testing, in particular to care home visitors, and that work was underway with care homes to put in systems of testing, and lateral flow testing, in place for visitors. Pilots had been undertaken of community testing in Johnstone and two areas within Glasgow in December 2020. In Johnstone, this had been lateral flow testing, with very few positive cases; there had been more positive cases in the other two pilots. Learning had been taken from the pilots in terms of how to expand mass testing to targeted / high risk areas.		

	Prof de Caestecker also noted that twice weekly lateral flow testing had been implemented for staff, as well as for all emergency and elective patient admissions. Prof de Caestecker confirmed that we had been vaccinating staff with the Pfizer vaccine, and were managing the logistical challenges as a result of the very low temperature required for storage. This was being rolled out based on priority, with health care staff at the front line and care home staff / residents being vaccinated first. Upon receipt of the AstraZeneca vaccine, which should be at end of December 2020, the vaccination programme will move to those aged 80+ years and all front line staff. Mr Jonathan Best was invited to give an overview on how Acute Services were coping with the pandemic. Mr Best confirmed that hospital sites remained challenged, with positive COVID-19 inpatients peaking at 702. This had declined to 675 in the last 24 hours. There had been a slow decline of COVID-19 patients in ICU, but that had risen from 18 to 22. 22 wards were closed due to COVID-19, and this created a challenging picture, with the need to continue to prioritise cancer and trauma patients. Mr Best confirmed that winter plans were in place, and that on a positive front, the number of staff absences as a result of shielding has come down. Mr Matthews thanked Prof de Caestecker and Mr Best, and invited questions from members. Ms Forbes welcomed the news about the AstraZeneca vaccine, and asked whether there were plans to use the Moderna vaccine, which had recently been approved for use in the USA. Prof de Caestecker noted that the initial batch of the AstraZeneca vaccine would be small, and that there had been no national advice about the Moderna vaccine thus far. Ms Forbes also asked about the new strain of COVID-19 reported in the media. Prof de Caestecker confirmed this could not be picked up through PCR testing; only through genome sequencing testing. There had been 18 cases of the new strain so far in Scotland. Ms Mhairi Hunter asked, in view of what had been reported about the new strain being more infectious in young people, whether any consideration had been given to adding secondary school teachers to the priority list. Prof de Caestecker reaffirmed the current priority list, which was subject to change, and based on national guidance. Ms Rona Sweeney asked how many people had been vaccinated, and when the vaccination programme would be complete. Mr Edwards confirmed that 11,200 people had been vaccinated as of 18 December 2020, and Ms Grant confirmed that the plan was to vaccinate 15,000 staff and care home residents by the end of December 2020. Prof de Caestecker said it was estimated the vaccination programme would be complete by Spring / Summer, but that was dependent on availability of the vaccines. Ms Sweeney also asked about lateral flow testing. Prof de Caestecker described that lateral flow testing worked best if the person was symptomatic, and therefore it was helpful that we were testing staff twice weekly, as the regularity increased the sensitivity; when infrequent, it could result in false negatives.		

	Ms Amina Khan asked what risk mitigation was in place for staff self-isolating. Ms Anne MacPherson, Director of Human Resources and Organisational Development, confirmed that 800 staff had been off work for COVID-19 related reasons, and that number had reduced to 525. Ms MacPherson also described the lateral flow testing underway, with 9000 kits distributed across several sites, and confirmed that staff were required to self-isolate if they tested positively for COVID-19. Ms MacPherson described that worst case scenario predictions were 4% for Covid-19 related absence, and that planning was in place. Ms Khan also asked about progress in relation to delayed discharge and the elective programme. Mr Best noted that there were currently 202 delayed discharges, and that this was an issue which remained challenging for both Acute Services and the HSCPs. In terms of the elective programme, Mr Best confirmed that we were keeping in touch with patients via different methods to keep them abreast of waiting times, and that the cancer programme was now back up to full capacity, with referrals exceeding pre COVID-19 levels. There was a remobilisation plan, but it was an evolving picture, and Ms Grant stressed the current context, in that there were more COVID-19 positive inpatients in hospital now than there was at the peak of wave 1 in Spring 2020, and this would have an impact on the elective programme. Mr Matthews commented on how well operational teams were doing, and commented on his recognition of the challenges that January and February 2021 would likely bring. Ms Flavia Tudoreanu asked about breast feeding women being a priority for vaccination. Prof de Caestecker replied that it had not yet been recommending that breast feeding women get vaccinated. Ms Speirs asked about workforce challenges. Ms Grant commented that here were a number of priorities that impact staff, including Test and Protect, vaccinations, and managing COVID-19 positive inpatients. Current staffing resource was therefore being maximising, as was the staffing resource to via the Staff Bank. In addition, Human Resources colleagues were working with services to speed up recruitment process, as well as recruiting additional staff. Ms MacPherson also confirmed that to manage this, staff were considered in different cohorts. Recently retired staff had been utilised, as had contractors. It had been challenging to balance, but supported by trade unions. Ms Speirs also asked about Out of Hours Services. Ms Grant confirmed there had not been a big impact on GP Out of Hours, and Mr Best and Dr Armstrong confirmed that the new flow navigation hub had made some impact to Emergency Departments within hours (10:00 – 22:00). Additional awareness and clinical pathways would increase the impact further. Ms Bustillo noted that communication around contacting 111 before attending the Emergency Departments would begin in January. Mr Allan MacLeod asked about utilising resource in other Health Boards, including the Golden Jubilee National Hospital, but Ms Grant noted that neighbouring Health Boards were equally as challenged.		

	Mr Matthews commented on the helpfulness of the discussion, and hoped that Board members were assured by the responses to their questions. **NOTED**		
103	**NHSGGC PERFORMANCE UPDATE**		
	The Board considered the paper 'Board Performance Summary Report' [Paper No. 20/67] presented by Mr Mark White, Director of Finance. The paper provided an overview of the current performance position across NHSGGC in relation to a number of high level key performance indicators. Mr White highlighted that the paper was set against the second phase in the Remobilisation Plan, and performance had been starting to improve, for example, in elective work, despite the pressures. Mr White described that outpatient targets had been more of a challenge. Mr Matthews thanked Mr White, and invited questions from members. Ms Speirs asked about visibility to members on 2020/21 planning. Mr White confirmed that the targets were under revision due to the changing COVID-19 position, and the aim was for it to come to a Board meeting in early 2021. Ms Kerr asked to what extent there would be a national message about this. Ms Grant confirmed that the Board was working with the Scottish Government, and that although this was within a framework, Boards would have a level of autonomy, given that there are different positions for Boards based on prevalence within the geographical area. Mr Charles Vincent asked what was being done regarding the gap in CAMHS referrals. Ms Grant confirmed that the team had worked hard on a full recovery plan and the activity target had been reached, but there remained challenges, due to the demand on the service. Ms Susan Manion, Chief Officer, noted that all HSCPs were focussed on this matter, to ensure that children and young people had access to the service within waiting time guarantees. There was therefore focus on reducing long waits, as well as the response to referrals. Cllr Bamforth commented that the Scottish Government and local authorities were providing significant support for children and young people through, for example, school counselling. Ms Manion acknowledged additional funding that had been invested, and commented that each of the HSCPs were doing work to engage local authorities and the third sector to support children and young people at the earliest opportunities, however, it was not just funding related; it was also dependent, for example, on being able to recruit staff with the right expertise and knowledge. Mr Matthews thanked Mr White for the paper and presentation, and members for the discussion. **NOTED**		

104	**HEALTHCARE ASSOCIATED INFECTION REPORT**		
	Prof Angela Wallace, Interim Director of Infection Prevention and Control (IPC), was invited to present on her paper 'The Healthcare Associated Infection Reporting Template (HAIRT)' [Paper No. 20/68]. This paper was is a mandatory reporting template which was issued by SG designed to provide assurance in relation to infection prevention and control, including targets, and how NHSGGC responded to issues. Prof Wallace noted that she wished to draw members' attention to four key areas: 1. The Annual Operation Plan target in relation to SABs, CDI and E.coli bacteraemias. Prof Wallace highlighted that we continued to be in a reasonable position in terms of progress against 2022 targets. We were slightly behind for E.coli, and Prof Wallace noted that the Scottish Government continued to review this target in light of emerging evidence. The December 2020 position showed that all figures were within control limits. Prof Wallace noted the fantastic effort from staff in relation to achieving this; 2. COVID-19. Prof Wallace noted that in relation to COVID-19 from an IPC perspective, the focus of the IPCT was supporting staff to implement national guidance to reduce transmission of the virus. Prof Wallace noted that the national position in relation to definite hospital onset was around 2.1% and NHSGGC was at 2.6% This was not unexpected as the community prevalence rate in GG has been one of the highest in Scotland for some weeks and GGC has the most deprived and diverse population in Scotland both risk factors for both acquisition and poor outcomes. Prof Wallace also noted the challenges of wards closures due to COVID-19. 3. There were a range of activities that staff undertake to assure quality and prevent avoidable infections. Prof Wallace confirmed there had been one new outbreak in Glasgow Royal Infirmary, but swift actions taken to avoid a recurrence; 4. Prof Wallace highlighted an overall stable performance against targets. Ms Tudoreanu noted an inconsistency, and Prof Wallace apologised for an error in the report with regards to the SAB rate. Mr Vincent asked if the HAI figures for COVID-19 included staff, and Prof Wallace confirmed that they did not; it was for patients only. Mr Vincent also asked about work on identifying methods of transmission (for example, was it patient to patient, patient to staff, and so on). Prof Wallace confirmed that this was constantly looked at; a hypotheses would be formed, tested and considered. NHSGGC is also participating in UK wide studies in relation to this issue. In addition, all raw data was sent to Health Protection Scotland, who validate it. There were also weekly meetings with the Scottish Government, and ARHAI which included consideration of what was happening in other Health Boards. Prof Wallace noted that a major challenge was the asymptomatic presentation of COVID-19 which is why regular staff testing was in place. Ms Forbes thanked Prof Wallace for a comprehensive report, and noted that a year on from being put on special measures, it would be helpful to see a comparison of the position from the same time last year. Prof Wallace confirmed she was happy to arrange that, however, 2020 had		**Prof Wallace**

	been very unusual, which made comparisons more difficult. However she underlined that over time, NHSGGC's performance has been improving. Mr Matthews also made reference to the special measures, asking how much the Scottish Government were aware of the improvements. Prof Wallace confirmed that updates have been given, to demonstrate the systematic improvements. Mr Matthews thanked Prof Wallace, noting that members were keen to understand this, and see NHSGGC be de-escalated. Ms Brimelow asked, on a related point, for assurance that the recommendations within the Interim Report would be acted upon at the earliest opportunity. Ms Grant confirmed that they would be, with a high degree of priority and rigour. Mr Matthews thanked members for a good discussion, and complemented Prof Wallace on a thorough report. **NOTED**		
105	**NHSGGC FINANCE UPDATE**		
a)	**FINANCIAL PLAN 2020/21**		
	Mr White was invited to present his paper 'Finance Report' [Paper No. 20/69]. Mr White explained that the report was the position at Month 7, and included the projection to the end of the financial year. It also included a high level initial outlook into 2021/22. Mr White noted the interim position of the COVID-19 funding allocations from Scottish Government to help remobilisation, and confirmed that further allocations were expected to come at the end of the financial year. A 'break even' position was expected for this financial year, but Mr White stressed that that this was dependent on the winter months, and the outcome of discussions regarding additional allocations. Mr White noted that 2021/22 was likely to be a challenge, but figures would be formalised. Mr MacLeod noted that there had been a recent and detailed discussion at the Finance, Planning and Performance Committee meeting, and that it was reassuring from the Board's perspective that the Scottish Government appeared to recognise the disproportionate impact of COVID-19 financially, and that was likely to be reflected in reimbursement levels. Mr MacLeod noted his thanks to Mr White and his team for making a strong case. Mr Matthews also noted his thanks to Mr White, and expressed that he too was pleased that the disproportionate financial weight of COVID-19 had been recognised. **NOTED**		

106	**DRAFT STAKEHOLDER COMMUNICATION AND ENGAGEMENT STRATEGY**		
	Ms Bustillo was invited to present her paper 'Draft Stakeholder Communications and Engagement Strategy' [Paper Np. 20/70]. Ms Bustillo noted that she had taken a previous draft to members at the Board meeting in October 2020, and had amended the draft strategy based on the comments and feedback received. Since then, further engagement had taken place with external stakeholders, and it had also gone to Health Improvement Scotland Community Engagement team for review. Further revisions were also made to the draft presented, based on this work. Ms Grant confirmed that she and Ms Bustillo had met with the Scottish Government's Head of Communication for ratification of the approach within the strategy. Members were invited to ask questions, and Ms Brimelow asked whether the strategy addressed recommendations within the Interim Report. Ms Grant confirmed that it did, and that Ms Bustillo and Dr McGuire would meet with Professor Craig White from the Scottish Government in the New Year to reaffirm this. Ms Speirs thanked Ms Bustillo, noting that comments previously made had been reflected in the updated draft. She also asked about the annual delivery plan and timing with the action plan. It was confirmed that this would go to the Corporate Management Team in February, and Finance, Planning and Performance Committee thereafter. Ms Khan noted she was happy to approve the strategy, and welcomed the call for engagement, especially with vulnerable groups and those with protected characteristics. She asked about the capacity and resources of the equalities team to engage with BAME patients. Ms Bustillo confirmed she had worked closely with the Equalities Team, and would continue to do so. Ms Monaghan commented that she felt the strategy was an excellent document, that she was encouraged by it, and felt it would be useful in building a positive reputation. She asked about the learning that would take place, and Ms Bustillo noted that there was learning for staff (including training materials), learning for services (in terms of taking on board patient feedback) and national learning. Mr Matthews thanked Ms Bustillo and the team, noting the sense of achievement. **APPROVED**		
107	**BREXIT UPDATE**		
	The Board considered the paper 'Withdrawal from the European Union (Brexit)' [Paper No. 20/71]. Ms MacPherson noted that all Board business continuity plans had been updated, risk assessments were in place, and scenario planning had been undertaken. Ms MacPherson also highlighted that recruitment, in terms of staff being registered through the Settlement		

	Scheme was being addressed, and refreshed communications materials (such as FAQs, videos and Core Briefs) had been arranged. For radiopharmaceuticals, the method of delivery had changed to air, to avoid any hold ups en route, an issue previously highlighted to the Board. Ms MacPherson confirmed she had been given assurance of stock supply, including medicines, and that there were no issues in goods coming into the UK. Between experiences and lessons learned from COVID-19, Ms MacPherson noted that NHSGGC was prepared, and continued to work conscientiously, including with community and care home colleagues. Mr Shennan noted that given the rapidly changing situation, this appeared to be good piece of planning. With regards to radiopharmaceuticals, Mr Shennan asked whether any problems were anticipated with paperwork. Ms MacPherson confirmed that suppliers were dealing with all the import documentation, it had been discussed by both local and national procurement, and no issues were foreseen. Cllr Bamforth asked whether there were any long term plans to keep stocks of medicines. Ms MacPherson replied that we were guided by both Scottish and UK Government regarding stocks, who dissuaded from stockpiling for more than 6 weeks supply worth of what was required. Ms MacPherson said she was not aware of any cost issues coming through from any suppliers at the moment. Mr Matthews thanked Ms MacPherson. **NOTED**		
108	**MINUTES OF BOARD GOVERNANCE COMMITTEE MEETINGS**		
a)	**ACUTE SERVICES COMMITTEE**		
	The Board considered the paper 'Acute Service's Committee Chair's Report' [Paper No. 20/72], presented by the Chair of the Acute Services Committee, Mr Ian Richie. Mr Richie made reference to the earlier updates at the Board meeting from Mr Best and Mr White. Mr Ritchie also commented being reassured by a presentation on the major trauma centre, and additional changes that were being made, and that these should have a positive impact on services. The Board were content to note the minutes of the Acute Services Committee meeting held on 22 September 2020 [Paper No. ASC(M) 20/03]. **NOTED**		
b)	**CLINICAL AND CARE GOVERNANCE COMMITTEE**		
	The Board considered the paper 'Clinical Care and Governance Committee's Chair's Report' [Paper No. 20/73], presented by the Clinical Care and Governance Committee Chair, Mrs Brimelow.		

	The Board were content to note the minutes of the Clinical Care and Governance Committee meeting held on 15 October 2020 [Paper No. CCG(M) 20/03]. **NOTED**		
c)	**AREA CLINICAL FORUM**		
	The Board considered the paper 'Area Clinical Forum's Chair's Report' [Paper No. 20/74], presented by the Chair of the Area Clinical Forum, Ms Audrey Thomson. Ms Thomson described that the latest meeting of this committee had discussed at great length the priority groups of staffing for vaccinations, and were content with the prioritisation levels, recognising it was based on risk. There was a welcome of focus on staff wellbeing. The Board were content to note the minutes of the Clinical Care and Governance Committee meeting held on 8 October 2020 [Paper No. ACF(M) 20/07]. **NOTED**		
d)	**FINANCE, PLANNING AND PERFORMANCE COMMITTEE**		
	The Board considered the paper 'Finance, Planning and Performance Committee's Chair's Report' [Paper No. 20/75], presented by the Chair of the Finance, Planning and Performance Committee, Mr Simon Carr. Mr Carr noted a proposal to commission Scott Moncrief to do some work on governance, and that there would be further discussions in the New Year regarding this with Prof Brown, Ms Vanhegan and Scott Moncrieff. Mr Carr also described that he and Ms Vanhegan were working on how to further establish the panning aspect of the committee. The Board were content to note the minutes of the Committee meeting held on 13 October 2020 [Paper No. FPPC(M) 20/04]. **NOTED**		
e)	**STAFF GOVERNANCE COMMITTEE**		
	The Board considered the paper 'Staff Governance Committee's Chair's Report' [Paper No. 20/76], presented by the Chair of the Staff Governance Committee, Mr Alan Cowan. Mr Cowan described the Whistleblowing Review currently being undertaken by Mr Vincent and Mr Kenny Small. Mr Vincent had brought an interim recommendation forward prior to completion of the review, related to finding a number of issues that had deemed not to be whistleblowing, and a need to tighten the process on making that decision. This had been agreed. Ms Brimelow asked about a previous issue about feedback from recommendations made as part of a whistleblowing investigation. Mr Cowan had confirmed that he had met with Mr Vincent and Ms Jennifer		

	Haynes, Corporate Services Manager, to discuss that matter, and was happy about the work being taken forward to improve this. The Board were content to note the minutes of the Committee meeting held on 18 August 2020 [Paper No. SGC(M) 20/02]. **NOTED**		
f)	**AUDIT AND RISK COMMITTEE**		
	The Board considered the paper 'Audit and Risk Committee's Chair's Report' [Paper No. 20/77], presented by the Chair of the Audit and Risk Committee, Mr Allan MacLeod. Mr MacLeod noted the balance of internal audit resources, against a background of COVID-19 and the balance carried forward. A draft work plan was in place for next year. The Board were content to note the minutes of the Committee meetings held on 8 September 2020 [Paper No. ARC(M) 20/02] and 22 September [Paper No. ARC(M) 20/03]. **NOTED**		
g)	**PUBLIC HEALTH COMMITTEE**		
	Mr Matthews noted there had been an ad hoc meeting of the Public Health Committee on 27 November 2020. This had considered the COVID-19 vaccine position, the flu vaccine programme, and the test and protect service. **NOTED**		
109	**AOCB**		
	Ms Grant highlighted that she and Prof Brown had agreed ongoing light governance arrangements in light of the COVID-19 position, which meant shorter and more focussed agendas. This would be reviewed in the New Year, with the possibility that the Board will have to move back to an interim Board arrangement. It was noted that there was a Board meeting scheduled for 19 January 2021, which was a private session, specifically to a legal case. Mr Matthews wished his best wishes to members for a happy Christmas, and thanked them for their attendance and contribution.		
110	**DATE OF NEXT MEETING**		
	Tuesday 23 February at 09:30am, MS Teams		

NHSGGC (M) 21/01
Minutes: 01 - 04

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the
NHS Greater Glasgow and Clyde Board
held on Tuesday 19th January 2021, at 1.00pm
via MS Teams

PRESENT

Prof John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Cllr Caroline Bamforth
Ms Susan Brimelow OBE	Mr Alan Cowan
Cllr Jim Clocherty	Prof Linda de Caestecker
Ms Jacqueline Forbes	Ms Jane Grant
Cllr Mhairi Hunter	Ms Margaret Kerr
Ms Amina Khan	Mr Allan MacLeod
Mr John Matthews OBE	Cllr Jonathan McColl
Ms Dorothy McErlean	Dr Margaret McGuire
Cllr Sheila Mechan	Ms Ketki Miles
Ms Anne Marie Monaghan	Mr Ian Ritchie
Ms Paula Speirs	Ms Rona Sweeney
Mrs Audrey Thompson	Mr Charles Vincent
Mr Mark White	

IN ATTENDANCE

Mr Jonathan Best	..	Chief Operating Officer
Ms Sandra Bustillo	..	Director of Communications and Engagement
Mr William Edwards	..	Director of eHealth
Mr Graeme Forrester	..	Deputy Head of Corporate Governance and Administration
Mrs Jennifer Haynes	..	Corporate Services Manager – Governance
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 Service
Mrs Geraldine Mathew	..	Secretariat Manager (Minute)
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

			ACTION BY
01.	**WELCOME AND APOLOGIES**		
	The Chair welcomed those present to an additional meeting of the NHS Greater Glasgow and Clyde Board, the first meeting of 2021. The meeting combined members joining via video conferencing, members of the public observing via video conferencing, and a socially distanced gathering of some members within the Boardroom of JB Russell House. Members were asked to observe the standard etiquette protocol, and presenters were asked to provide short		

	presentations to highlight key points. In addition, the Chair highlighted that members of the public had been invited to observe the meeting, and as such were reminded to ensure mics were on mute throughout the meeting. Apologies were intimated on behalf of Cllr Iain Nicolson and Mr Francis Shennan. Prof Brown detailed the items included on the agenda, those being a presentation on the ongoing response to the COVID-19 pandemic and a paper to consider the Governance Review Update. In addition, a third item of business would be considered, that being the Queen Elizabeth University Hospital(QEUH) and Royal Hospital for Children (RAH) Legal Position, following the Board's decision in December 2020 which required the Chief Executive to instruct MacRoberts LLP to act on behalf of NHSGGC Board to raise appropriate court proceedings. **Invoking of Standing Order 5.22 – Resolution to take Agenda Item 5 in Private Session** Prof Brown invited members to consider the proposal to resolve to invoke *Standing Order 5.22 – Board Meeting in Private Session,* in order to consider *Agenda Item 5 – QEUH/RHC Legal Position Update.* The Board resolved to invoke *Standing Order 5.22 – Board Meeting in Private Session* in order to consider *Agenda Item 5 – QEUH/RHC Legal Position Update.* **APPROVED**		
02.	**DECLARATIONS OF INTEREST**		
	Prof Brown invited Board members to declare any interest in any of the items to be discussed. There were no declarations made. **NOTED**		
03.	**COVID-19 UPDATE**		
	Ms Jane Grant, Chief Executive, provided a presentation on the current position in respect of the response to the COVID-19 pandemic. The presentation covered a number of key areas including current community prevalence; current impact on Acute and Health and Social Care Partnership (HSCP) services; Care Homes' Support; and the COVID-19 Vaccination programme. Community Prevalence Prof de Caestecker, Director of Public Health, provided an overview of current community prevalence. She noted that infection rates remained elevated and the Test and Protect Service continued to respond to the challenge. From 8th January 2021 to 14th January 2021, a total of 4,089 cases were reported to the Test and Protect Service. However, it was noted that the number of contacts of an infected individual had reduced which indicated that current social distancing restrictions were having a positive impact on transmission. The current level of infection was 330 cases per 100,000.		

Acute Services Position

Mr Jonathan Best, Chief Operating Officer, provided an overview of the current position in respect of Acute Services. He noted that the service remained under pressure to respond to the impact of relaxation of restrictions during the festive period. Daily meetings were taking place to manage the situation and there were 526 inpatients within the last 28 days, and a total of 907, an increase of 49% above the position reported in April 2020. There were a total of 1,272 staff absent due to COVID-19 infection, self-isolation, and shielding, and a total of 16 Wards closed due to COVID-19. In respect of the elective position, Mr Best noted that focus continued to manage Priority 1 and 2 patients, and support from Golden Jubilee National Hospital (GJNH) was in place to maintain this.

HSCP Position

Ms Susanne Millar, Interim Chief Officer, Glasgow City HSCP, provided an overview of the current position within HSCPs. The Community Assessment Centres (CACs) remained active. There were currently 5 CACs in operation, with a total of 668 contacts within the last 9 days. Daily oversight of the activity of the CACs and the virtual hubs continued to ensure ongoing management of the position. In respect of delayed discharges, Ms Millar assured members that this remained a key focus, however challenges continued due to a number of care homes closed to new admissions due to COVID-19, with a total of 42 care homes currently experiencing an outbreak. Colleagues within HSCPs and Acute Services continued to work closely to manage the position, and an action plan was in place. The Mental Health Assessment Units (MHAUs) continued to work well and Ms Millar noted the essential work carried out by the MHAUs.

Care Homes Support

Prof de Caestecker, Director of Public Health, provided an overview of the current position in respect of the support being provided to care homes. She noted that there continued to be challenges in respect of care home outbreaks, and assured members that data on care homes staffing levels, infections, and vaccination rates, was reviewed on a daily basis to identify and deploy appropriate support. Daily meetings with a range of multi-disciplinary and HSCP colleagues were in place, as were weekly meetings with Care Inspectorate colleagues.

COVID-19 Vaccination Programme

Prof de Caestecker provided an overview of the current position in respect of the COVID-19 Vaccination Programme. She noted that there were two vaccinations approved for use in the first phase of the vaccination programme, those being the Courageous (Pfizer) vaccine and the Talent (Oxford/AZ) vaccine. A third vaccine, the Moderna vaccine, had also been approved for use in the first phase of the programme, however this vaccine was unlikely to be available in the UK until March/April 2021. Prof de Caestecker highlighted the confirmed Priority Groups for the first phase of the programme, as detailed within the Chief Medical Officers letter. These included:

- Care Home residents in Care Homes for Older Adults;
- Care Home workers in Care Homes for Older Adults;
- Healthcare staff working with direct face to face contact in healthcare settings;
- Long stay inpatients aged over 80 years old;
- Individuals over 80 years old in the community;
- Social care front facing staff.

Vaccination of the above priority groups commenced in December 2020, and would be completed by 5th February 2021, with circa 100,000 people vaccinated.

From 1st February 2021, a further circa 188,000 people would be vaccinated in the following groups:

- Commencement of second dose for the first priority groups;
- People over the age of 65 years;
- People on the shielding list.

In summary, COVID-19 cases remained elevated, and it was anticipated that this would increase. Hospital bed demand was significantly higher than that of the first wave and with Care Homes continuing to require significant support. The COVID-19 Vaccination Programme was progressing well.

Prof Brown thanked Ms Grant, Prof de Caestecker, Mr Best and Ms Millar, for the updates provided. He commended the work of Ms Grant and the Executive Team for their ongoing commitment to manage the emergency situation. He expressed gratitude on behalf of the Board to all staff across health and social care services, and external partner organisation staff, for their ongoing support and commitment to manage the position. He invited comments and questions from members.

In response to a question regarding the elective programme sessions being undertaken at the GJNH and if these were staffed by NHSGGC staff or GJNH staff, Mr Best confirmed that, elective work undertaken by the GJNH as part of the Service Level Agreement (SLA) in place was staffed by GJNH staff. Additional support undertaken by GJNH out with the SLA, has been undertaken with a mix of both GJNH and NHSGGC staff. A further question was raised about the impact of staff absence due to self-isolation and shielding within GJNH. Mr Best advised that the GJNH had experienced a similar level of absence to that of NHSGGC.

A question was raised regarding the current impact of COVID-19 restrictions on attendances and activity at Emergency Departments (EDs). Mr Best explained that there had been a reduction in attendances at ED and described the current arrangements in respect of unscheduled care, including the Specialist Assessment and Treatment Area (SATA); the ED; and the GP Assessment pathway.

In response to a question regarding the 16 wards closed due to COVID-19 and if this included mental health wards, Mr Best confirmed that the wards alluded to did not include mental health wards.

A question was raised regarding the care homes currently closed to new admissions, and what proportion of care homes this represented. Ms Millar confirmed that this represented approximately just over one third of care homes across NHSGGC. She reported that, in some HSCP areas, this represented approximately half of care homes. This issue remained a quickly changing and complex position.

In response to a question regarding the MHAUs and if there were any delays associated with commencement of treatments such as psychological therapies,

	Ms Millar explained that there was a substantial amount of data available regarding access, referrals and performance. Furthermore, access to psychological therapies formed part of the Remobilisation Plan of mental health services which continued to be progressed. Prof Brown confirmed that an update on progress of the full Remobilisation Plan would be presented to the Board at the February 2021 meeting. A question was raised regarding uptake of the COVID-19 vaccination amongst care home staff and if there was any evidence to suggest staff were reluctant to receive the vaccination. Prof de Caestecker advised that there had been some concern that some younger care home members of staff were reluctant to receive the vaccination due to misinformation circulating on social media, however she assured members that there had been a very high uptake of the vaccination amongst care home staff. This was due to the immunisation staff visiting the care homes to provide information to the staff members, at the time of immunisation. Furthermore, Ms Bustillo, Director of Communications and Engagement, and the Communications Team, were fully involved in planning activities in respect of the vaccination programme. In addition, Dr Syed Ahmed, Clinical Director and Consultant in Public Health Medicine, had been working on producing Webinars for care home staff to ensure they receive correct information and to diffuse any myths about vaccination. In response to a question raised regarding the availability of data to demonstrate the vaccination uptake rate, Prof de Caestecker advised that data would be available in February 2021, which would indicate the uptake rates amongst the first priority groups. A question was raised regarding the common side effects of the vaccines and if this information was available online. Prof de Caestecker advised that there were few, mild side effects reported. This information was collated on a national basis, therefore agreement to publish a list of common side effects would remain a national decision. Discussion took place regarding patient stories and the potential to feature patients who had been vaccinated. Ms Bustillo highlighted a recent patient story of a patient being vaccinated on their 108th birthday. She assured members that good progress was being made in respect of communications regarding the vaccination programme. Prof Brown wished to note thanks on behalf of the Board to Ms Bustillo, and the Communications Team for their efforts to ensure ongoing external and internal communications throughout this challenging period, and acknowledged their hard work and efforts. In response to a question regarding the impact of COVID-19 on health inequalities and what actions were being taken to address this, Prof de Caestecker advised that this been taken into account when planning the locations of the mass vaccination clinics, a number of which were being located within the most deprived communities to ensure accessibility. Furthermore, she assured members that this would be closely monitored to ensure additional support which may be required by specific communities. A further question was raised about the vaccination of Black and Minority Ethnic (BME) staff members, and Prof de Caestecker advised that staff who identified as being within the BME community, were invited to attend for vaccination during the initial roll out and there had been a positive response to this.		**Ms Grant/ Dr Armstrong**

	In summary, the Board were content to note the update provided on the progress of the response to COVID-19, including community prevalence; the current impact on Acute Services and HSCP Services; ongoing support provided to Care Homes; and the COVID-19 Vaccination Programme. **NOTED**		
04.	**GOVERNANCE REVIEW UPDATE**		
	The Board considered the paper 'Greater Glasgow and Clyde NHS Board - Amended Governance Arrangements – January 2021' [Paper No. 21/01] presented by Prof John Brown CBE, Chair of NHS Greater Glasgow and Clyde. The paper provided an update on proposed alterations to the governance arrangements of the Board, which acknowledged the current pressures of the COVID-19 pandemic. Prof Brown provided an overview of the paper, and confirmed that the Standing Committee Chairs had been consulted with and and had approved the proposal. In addition, Scottish Government colleagues had been consulted with and the Interim Director for Health, Finance and Governance, Mr Richard McCallum, had approved the proposal. The Internal Auditors had also been consulted with and had provided guidance in respect of the content of the proposal. Prof Brown confirmed that the proposal met the requirements outlined by the Cabinet Secretary, which asked Board Chairs to ensure that the Executive Team were supported and to review the non-critical Committees and groups which required the input of the Chief Executive and key Directors. Prof Brown invited comments and questions from members. In response to a question regarding the inclusion of quality of care, Prof Brown agreed that this was an important area which would be included as part of the COVID-19 update moving forward. In summary, the Board were content to approve the amendment to the current focused governance arrangements and acknowledged that this would be reviewed in March 2021. Prof Brown highlighted the importance of the continued contributions of the Area Partnership Forum; the Area Clinical Forum and the Endowments Committee. In addition, the Chair of the Area Clinical Forum would be asked to consider with Area Clinical Forum members, the requirement for ongoing meetings of the Area Clinical Forum Subcommittees. All Standing Committees were asked to review and approve any draft minutes electronically, and any matters arising would be updated to the Board at the next meeting in February 2021. **APPROVED**		**Dr Armstrong/ Ms Grant** **Secretary/ Standing Committee Chairs**
	The meeting concluded at 2pm. A Private Session of the Board commenced, as agreed, at 2.15pm to consider *Agenda Item 05 - QEUH/RHC Legal Position Update*.		

OFFICIAL SENSITIVE
DRAFT – TO BE RATIFIED

NHSGGC(M) 21/06
Minutes 80 - 88

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the NHS Greater Glasgow and Clyde Board held on Tuesday 21 September 2021 at 1:30pm via Microsoft Teams

PRESENT

Professor John Brown CBE (in the Chair)

Dr Jennifer Armstrong	Dr Margaret McGuire
Cllr Caroline Bamforth	Cllr Sheila Mechan
Mr Simon Carr	Ms Ketki Miles
Cllr Jim Clocherty	Ms Dorothy McErlean
Mr Alan Cowan	Professor Iain McInnes
Professor Linda de Caestecker	Cllr Iain Nicolson
Ms Jacqueline Forbes	Mr Ian Ritchie
Mrs Jane Grant	Dr Lesley Rousselet
Cllr Mhairi Hunter	Dr Paul Ryan
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

Ms Lesley Aird	..	Assistant Director of Finance - Financial Services, Capital & Payroll
Mr John Cornett	..	Audit Scotland
Ms Beth Culshaw	..	Chief Officer, West Dunbartonshire HSCP
Ms Lisa Duthie	..	Audit Scotland
Ms Jennifer Haynes	..	Corporate Services Manager - Governance
Ms Lorna Kelly	..	Interim Director of Primary Care
Ms Liz Maconachie	..	Audit Scotland
Mrs Anne MacPherson	..	Director of Human Resources and Organisational Development
Mrs Geraldine Mathew	..	Secretariat Manager (Minute)
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

			ACTION BY
80.	**WELCOME AND APOLOGIES**		
	The Chair welcomed everyone to an additional meeting of the NHS Greater Glasgow and Clyde Board. The purpose of the meeting was primarily to consider the 2020/21 Annual Accounts		

			ACTION BY
	and to review the Annual Governance Statement and receive the Annual Reports from the Governance Committees. The Board were also being asked to respond to the paper on the review of the overall Governance Framework for NHSGGC. Professor Brown reminded everyone present of the online meeting protocol, microphones should remain on mute throughout until members were invited to speak; the virtual "hands up" function should be used when members wish to contribute; and members should refrain from using the chat function. Members of the public had been invited to observe the meeting and as such were reminded that as observers only, the "hands up" function should not be used, and observers must remain on mute throughout the meeting. Professor Brown acknowledged the current challenges experienced by the Executive Team, including the ongoing response to COVID-19, implementation of the latest phase of the vaccination programme including the seasonal flu vaccination programme; the considerable work to prepare for COP26; and the impact of the Scottish Hospitals Inquiry. Given these pressures, the papers for today's meeting were not circulated 7 days in advance of the meeting, and as such, Professor Brown asked if members were content to proceed, despite the understandable delay. Members were content to note the exception and proceed. Apologies were intimated on behalf of Ms Susan Brimelow OBE, Cllr Iain Nicolson, Ms Anne Marie Monaghan, Ms Flavia Tudoreanu, Ms Paula Speirs, and Mr Francis Shennan. **NOTED**		
81.	**DECLARATIONS OF INTEREST**		
	The Chair invited members present to declare any interests in respect of the items included on the agenda. There were no declarations made. **NOTED**		
82.	**ANNUAL REPORT FOR THE BOARD OF NHSGGC AND AUDITOR GENERAL FOR SCOTLAND 2020/21**		
	The Board considered the paper 'Annual Report for the Board of NHSGGC and Auditor General for Scotland 2020/21' [Paper No. 21/55] introduced by the Director of Finance, Mr Mark White. The report was presented for assurance and summarised the findings		

			ACTION BY
	from the 2020/21 audit of NHS Greater Glasgow and Clyde. Mr White invited Mr John Cornett, Audit Director, Audit Scotland, to provide an overview of the report. Mr Cornett provided an overview of the two key areas within the report, those being, the financial statement and the wider dimensions, and noted that the report had been scrutinised in detail by the Audit and Risk Committee, at its meeting of 14th September 2021 In respect of the accounts, Mr Cornett confirmed the intention to issue an unqualified opinion, that there was a true and fair view of the accounts. He highlighted the very high standard of work of the Finance Team within NHSGGC and wished to note particular thanks to Mr Mark White, Director of Finance, Ms Lesley Aird, Assistant Director of Finance – Financial Services, Capital and Payroll, Ms Fiona McEwan, Assistant Director of Finance – Finance Planning and Performance, and Mr Michael Sheils, Head of Financial Services, for their ongoing support throughout the process. Mr Cornett noted adjustments totalling £58m, which included adjustments of accruals transferred to Integration Joint Boards (IJBs) reserves, and a Scottish Government adjustment. He also noted adjustments made to the accounts after audit, out with the control of the organisation, specifically, adjustments made for Personal Protective Equipment (PPE). All adjustments were appropriately reflected and did not change the overall opinion. In respect of the wider dimensions evaluated, Mr Cornett noted the impact of COVID-19, and the importance of continuing efforts to address the underlying challenges including the Financial Improvement Programme. He noted the alterations made to governance arrangements and that these were evaluated as appropriate and effective to manage COVID-19 challenges. He also noted the Remobilisation Plan and ongoing amendments to performance reporting. Overall, this was a positive report, nevertheless, ongoing actions were required to address the underlying financial deficit and Mr Cornett was confident that these were being progressed. Mr Cornett noted the letter of representation contained within the report. He confirmed that there were no areas requiring representations, other than the standard requirements. Professor Brown thanked Mr White and Mr Cornett for the report. He noted thanks on behalf of the Board and commended the		

			ACTION BY
	Finance Team for their hard work and diligence. He invited comments and questions from members. In response to a question regarding the minor outstanding issues, Mr Cornett confirmed that these had now been addressed. In summary, the Board were content to note the attached report by the external auditors, Audit Scotland, on the 2020/21 audit of NHS Greater Glasgow and Clyde, and noted that the report had been fully reviewed by the Director of Finance, and scrutinised by the Audit and Risk Committee. **NOTED**		
83.	**ANNUAL REPORT AND CONSOLIDATED ACCOUNTS FOR 2020/21**		
	The Board considered the paper 'Annual Report and Accounts for 2020/21' [Paper No. 21/56] presented by the Director of Finance, Mr Mark White. The paper was presented for approval by the Board, and had been fully debated at the Audit and Risk Committee meeting of 14th September 2021. Mr White highlighted page 18 of the report which indicated that NHS Greater Glasgow and Clyde had achieved its three Scottish Government Health and Social Care Directorates (SGHSD) financial targets, those being, Revenue Resource Limit (RRL); Capital Resource Limit; and the Cash Requirement. Mr White noted that the financial performance of 2020/21 was very much influenced by COVID-19, in both income and expenditure. Professor Brown thanked Mr White for the report and invited comments and questions from members. There were no comments or questions raised. In summary, the Board were content to adopt the Annual Report and Accounts; authorised the Chief Executive to sign the Performance Report and Accountability Report; authorised the Chief Executive and the Director of Finance to sign the Balance Sheet; and agreed that the Statement of Accounts be submitted to the Scottish Government Health Directorates. **APPROVED**		
84.	**GOVERNANCE STATEMENT**		
	The Board considered the paper 'Governance Statement 2020/21' [Paper No. 21/57] presented by Ms Margaret Kerr, Chair		

			ACTION BY
	of the Audit and Risk Committee. The paper was presented for approval. Ms Kerr highlighted that the Governance Statement represented a statement of assurance by the Audit and Risk Committee, which had undertaken a full and in depth review of the accounts. The Audit and Risk Committee had received reasonable assurance and concluded that the Board were in a position to approve the Governance Statement. Professor Brown thanked Ms Kerr for the report, and noted thanks to Ms Kerr and the Audit and Risk Committee for their ongoing efforts and commitment. In summary, the Board were content to note the Statement of Assurance by the Audit and Risk Committee; and approved the Governance Statement which was part of the Annual Report and Accounts 2020/21, for signature by the Chief Executive. **APPROVED**		
85.	**GOVERNANCE FRAMEWORK REVIEW**		
	The Board considered the paper 'Governance Framework Review' [Paper No. 21/58] presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The paper was presented for approval and detailed the Governance Framework Review which included: • 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; • The Standing Committee Terms of Reference. Ms Vanhegan noted the work underway in respect of the Active Governance Programme, and highlighted that this may result in further review of the Governance Framework, as this work evolved.		

			ACTION BY
	Furthermore, Ms Vanhegan highlighted the recent Scottish Government consultation on the Model Code of Conduct. It was anticipated that the final, revised Model Code of Conduct and associated guidance, would be published circa December 2021. As soon as this was received, this would be presented to the Board, for formal adoption. Professor Brown invited comments and questions from members in respect of each of the documents contained within the Governance Framework. There were no comments or questions raised. Professor Brown highlighted some areas which he considered required further amendment, specifically, the Scheme of Delegation, and the Committee Terms of Reference. He noted that there were some areas which could be made clearer regarding the functions of Committees, where the Committee consider approval for onward transmission to the Board, versus where the Committee responsibility was to undertake a deep dive of a particular matter, for recommendation to the Board. In addition, Professor Brown considered that the Scheme of Delegation did not adequately reflect the relationship with Integration Joint Boards (IJBs), specifically, in relation to IJB Strategic Plans and an appropriate structure for consultation of these. Furthermore, an appropriate mechanism by which a suitable Committee could review the IJB Annual Reports was required. In summary, the Board were content to note the work undertaken in respect of the Governance Framework; noted the work underway in respect of the Active Governance Programme, and approved the key documents included within the Governance Framework, with the exception of the Scheme of Delegation which required further adjustment, prior to final approval at the October Board Meeting. **PARTIALLY APPROVED**		Ms Vanhegan
86.	**GOVERNANCE COMMITTEES - ANNUAL REPORTS 2020/21**		
	The Board considered the paper 'Governance Committees – Annual Reports 2020/21' [Paper No. 21/59] presented by the Head of Corporate Governance and Administration, Ms Elaine Vanhegan. The paper was presented for approval and included the Annual Reports for the period 1 April 2020 to 31 March 2021, of the following Committees:		

			ACTION BY
	• Audit and Risk Committee; • Finance, Planning and Performance Committee; • Clinical and Care Governance Committee; • Staff Governance Committee; • Acute Services Committee; • Population Health and Wellbeing Committee; • Area Clinical Forum. Professor Brown invited comments and questions on each of the above Annual Reports from members. There were no comments or questions raised. In summary, the Board were content to approve the Annual Reports of the above Committees for the period 1 April 2020 to 31 March 2021. Professor Brown wished to note thanks on behalf of the Board, to all of the Standing Committee Chairs and their members, for their diligence and ongoing efforts. Professor Brown also noted thanks to Ms Elaine Vanhegan, and the Corporate Governance and Administration Team for their hard work and commended their efforts. **APPROVED**		
87.	**DRAFT MINUTES OF THE AUDIT AND RISK COMMITTEE MEETING HELD ON 14th SEPTEMBER 2021**		
	The Board considered the draft minute of the Audit and Risk Committee Meeting of 14th September 2021 [Paper No. AR(M) 21/03] presented to the Board for assurance purposes. Ms Forbes highlighted a correction in respect of page 6 of the minute, and Professor Brown confirmed that this would be addressed at the next meeting of the Audit and Risk Committee on 14th December 2021. **NOTED**		
88.	**DATE OF NEXT MEETING**		
	The next meeting would be held on Tuesday 27th October 2021, 09:30am, via MS Teams. Professor Brown highlighted that Board meetings would continue to operate as hybrid meetings, with a combination of members		

			ACTION BY
	joining via MS Teams, and a socially distanced group of members gathering in the Boardroom. Professor Brown asked members if they wished to attend the meeting in person within the Boardroom, to contact Ms Vanhegan.		
	The meeting concluded at 2.53pm.		

Bundle of document for Oral hearings commencing from 16 September 2025 in relation to the Queen Elizabeth University Hospital and the Royal Hospital for Children, Glasgow

Bundle 42 – Volume 8
Previously Omitted NHS GGC Board Minutes

A53604347