

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 20 March 2012 in the
Board Room, J B Russell House
Gartnavel Royal Hospital, 1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

Mr I Lee (Convener)

Dr C Benton MBE	Councillor J McIlwee (to Minute No.36)
Ms M Brown (from Minute 22 to Minute No. 33)	Mr D Sime
Mr P Daniels OBE	Mrs P Spencer (to Minute 38)
Ms R Dhir MBE	Mr B Williamson
Mr I Fraser	Mr K Winter

Councillor D Yates

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

Mr R Calderwood	Mr P James
Dr L de Caestecker	Mr A O Robertson OBE

Rev Dr N Shanks (to Minute 34)

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

Mr A Curran	..	Head of Capital Planning (for Minute 38)
Mr A Crawford	..	Head of Clinical Governance (to Minute 29)
Dr J Dickson	..	Associate Medical Director
Mrs J Grant	..	Chief Operating Officer - Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Mr A McLaws	..	Director of Corporate Communications
Ms P Mullen	..	Acting Head of Performance and Corporate Reporting
Ms C Renfrew	..	Director of Corporate Planning and Policy
Mr D Ross	..	Director, Currie & Brown UK Limited (for Minute No. 37)
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (for Minute No. 37)
Ms G Woolman	..	Audit Scotland (to Minute 36)

ACTION BY

19. APOLOGY

An apology for absence was intimated on behalf of Councillor R McColl.

20. MINUTES OF PREVIOUS MEETING

On the motion of Mr B Williamson and seconded by Cllr D Yates, the Minutes of the Quality and Performance Committee meeting held on 17 January 2012 [QPC(M)12/01] were approved as a correct record, subject to the correct spelling of Mrs P Spencer's name.

NOTED

21. MATTERS ARISING

- (a) Rolling Action List

NOTED

- (b) Update on Rates of Severe Maternal Morbidity

In relation to Minute No. 3(d) – National Maternal Morbidity Report – there was a paper submitted [Paper No. 12/16] from the Clinical Director of Obstetrics and Gynaecology providing further comment at the Committee's request on the rise in severe maternal morbidity at Princess Royal Maternity in 2009, compared with 2006-2008 figures as described in the Scottish Confidential Audit of Severe Maternal Morbidity Annual Report – 2011. In addition an e-mail message had been circulated to members setting out the changes to the demographics of the east end of Glasgow following the re-distribution of asylum seekers across the UK. This has presented a further level of women with complicated pregnancies with diverse medical issues and variable access to previous medical care.

Members found the information helpful and in discussing the complexity of the issue asked Dr J Dickson, Associate Medical Director, Acute Services to ensure that this matter was kept under review within the local Clinical Governance structures in the acute services division and that it would be reported back to the Committee as part of next year's Annual Report on the Confidential Audit of Severe Maternal Morbidity.

DECIDED

1. That the information provided on the rise in severe maternal morbidity at the Princess Royal Maternity be noted.
2. That the issues discussed be monitored by the Acute Services Division's Clinical Governance structures.
3. That the 2012 Annual Report be submitted to the Committee with progress in this area highlighted.

**Associate
Medical
Director**

**Associate
Medical
Director**

- (c) Western Infirmary – Site B: Update

In relation to Minute No. 17 – Proposed Disposal of Site B, Western Infirmary – Mr Calderwood advised that negotiations were continuing with the University of Glasgow in an attempt to complete the sale of Site B by 30 June

2012. Discussion was centred on the claw-back arrangements discussed at the last meeting and the non-educational buildings.

A further report would be given to the Committee at its next meeting.

Chief Executive

NOTED

22. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No. 12/17] from the Acting Head of Performance and Corporate Reporting setting out the next iteration of bringing together high level performance information from separate reporting strands to create a more integrated view of the organisation's performance. The report aimed at providing an overall sense of where NHS Greater Glasgow and Clyde was in achieving the ambitions set out in the Quality Strategy and signposted sources of greater detailed information if required. It was acknowledged that the report was still work in progress but that Members were content as to how it was developing and as requested by members an additional element had been added to the report. An Exceptions proforma had been developed for those measures where performance was significantly off-track and currently rated as red; the aim was to provide Members with the reassurance that action was underway in addressing performance. In addition some indicators, particularly the Quality Outcome Measures, were still being developed nationally and the indicators continued to be included but without data; these indicators would be populated once definitions had been agreed. Data and targets had now been agreed for five measures since the last report, namely:

- Did Not Attend (DNA) rates
- suicide prevention training
- access to psychological therapies
- long-term conditions
- faster access to specialist services CAMHS

Mr Sime highlighted that violence and aggression incidents had been discussed a couple of years ago and it continued to be a concern. Mr Calderwood indicated that incidents relating to aggression within the clinical field had not previously been gathered and it was difficult to detect trends and he felt that lessons would be learned from each individual incident in order to mitigate a reoccurrence in the future. It was agreed that the local Health and Safety Committees should be asked to look at this issue and consider trends and any training or sharing of lessons across NHS GG&C. Any report back to Committee on progress made would be via the Integrated Quality and Performance Report.

**Director of
Human
Resources/Head
of Clinical
Governance**

Ms Dhir highlighted the continued problem of Did Not Attends (DNAs), whether double booking of clinics was possible and their effect on the service. Mrs Grant advised that a further worked-up plan to reduce the DNA rate was being developed and this included looking sensitively at clinics where over-booking was possible. Particular attention was being given to those specialties where the DNA rates were highest. Mr Calderwood advised that with shorter waiting times for patients it had been hoped the DNA rates would reduce, however this had not happened. Part of the message was advising patients of the impact on the service by not attending for their clinic or hospital appointment without giving prior notification.

The Convener asked about the progress in achieving the sickness absence target of 4%. Currently the short-term sickness was at 1.60% and long-term absence comprised 3.02% giving an overall average figure of 4.62%. Mr Calderwood

advised that real progress had been made with the implementation of the absence management policy and return to work interviews and the 1.60% short-term sickness was to be welcomed. However it was recognised that staff on longer-term sickness was a more intractable problem as staff in this position were entitled to the sickness leave arrangements set out in their contracts. The new streamlined Occupational Therapy Service was seeing such staff more regularly and making recommendations for different types of approaches to return to work.

The Convener raised concerns that progress was proving to be difficult in achieving the maximum wait of 26 weeks by March 2013 for faster access to specialist services (CAMHS). He noted the maximum wait was currently 57 weeks and some patients were waiting over 52 weeks in the north of Glasgow. Mrs Hawkins indicated that she was looking into the patients who were in excess of the 52 week period and progress would be provided in the next report to Committee.

**Director,
Glasgow CHP**

NOTED

23. SCOTTISH PATIENT SAFETY PROGRAMME: REPORT TO JANUARY 2012

There was submitted a paper [Paper No. 12/18] by the Medical Director setting out the progress for the implementation of the Scottish Patient Safety Programme (SPSP) reflecting the activity within NHS Greater Glasgow and Clyde to January 2012. The aim was to achieve full implementation of the core programme within the Acute Services Division by the end of December 2012. It was reported that the implementation of meeting the national medium term goals for Paediatric SPSP would be achieved by March 2012.

Mr A Crawford, Head of Clinical Governance, drew Members' attention to the latest release of Hospital Standardised Mortality Ratio data with the Southern General and Victoria Hospitals continuing to out-perform the national target. The variation at Stobhill Hospital was due to the change in activity following the move of acute services to the Glasgow Royal Infirmary and NHS Board has requested that this activity was aggregated in the Royal Infirmary figures in future. Encouragingly, the national team has ceased monitoring the Royal Alexandra Hospital figures and had passed monitoring back to the local Clinical Governance structures.

Mr Crawford drew attention to the two new programmes which have been added to the National Patient Safety Programme and also the progress being made in monitoring implementation and the Scottish Paediatric Patient Safety Programme.

NOTED

24. INFECTION CONTROL SERVICE – HAI REPORTING TEMPLATE – MARCH 2012

There was submitted a paper [Paper No. 12/19] by the Infection Control Manager covering the Board wide infection prevention control activity. As previously agreed the report was now on an exception reporting basis in order to cut down the duplication of the full report being submitted to the NHS Board meetings.

The NHS Board continues to work towards the revised 2013 HEAT target of 0.26 cases of Staphylococcus Aureus Bacteraemias (SABs) per 1000 occupied beds. The most recent results demonstrated a rate of 0.27 per 1000 acute occupied bed days.

The rate of Clostridium Difficile infection for the third quarter was 0.25 per 1000 occupied bed days and the second lowest rate achieved in NHS GG&C and below the 2013 HEAT target of 0.39.

NOTED

25. CLINICAL RISK MANAGEMENT REPORT: SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS

There was submitted a paper [Paper No. 12/20] by the Medical Director on adverse clinical incidents. The reporting of adverse clinical incidents had been displayed in two separate charts in order to highlight the position within Acute Services and separately within Partnerships.

Mr Williamson pointed out that the venous thrombo-embolism (VTE) excluded the hospitals within the Clyde area and Mr Crawford indicated that the report had not included the full set of VTE data at this stage. It was a relatively new addition, with monitoring only commencing at the beginning of 2011. This would be developed over time to include all relevant data.

Ms Brown welcomed further work within the Emergency Care and Medical Services Directorate in order that a better understanding was provided on the high numbers of significant clinical incidents within this Directorate. These would be monitored in future reports and Mr Crawford confirmed that to date there was no national benchmarking that this could be measured against.

Mr Sime asked if the significant clinical incidents had been triangulated and Mr Crawford confirmed this was the case and this information was used for clinical reviews.

Dr Dickson provided Members with a detailed summary on forthcoming Fatal Accident Inquiries. Mr Robertson asked about the support provided to staff who would be witnesses at Fatal Accident Inquiries and similar type events. Dr Dickson advised that there was a policy on StaffNet on providing support to witnesses; the Central Legal Office undertook a role to provide guidance and support to witnesses and quite often a staff member who had attended a previous hearing would offer to assist staff who were attending for the first time.

NOTED

26. THE MENTAL WELFARE COMMISSION – STARVED OF CARE – UPDATE ON IMPLEMENTING ACTIONS

There was submitted a paper [Paper No. 12/21] by the Director, Glasgow CHP and Chief Operating Officer, Acute Services Division, advising that the self-assessment against the recommendations of the Mental Welfare Commission Report – Starved of Care had been completed. The Committee had asked at its meeting in September 2011 to receive an update on the implementation of the Improvement Plan and this was attached for Members' information.

Mrs Hawkins advised that the Improvement Plan would form part of the work of the NHS Board's Dementia Strategy Group. Members welcomed receipt of the Improvement Plan. Dr Benton gave a personal account of the very difficult and sensitive issues which she had encountered that highlighted further improvements

were still required in providing person centred and patient sensitive services. Mrs Grant acknowledged that there were still improvements to be made in the areas described by Dr Benton and she hoped through implementing the improvement programme this would go some way to bring a greater consistency and higher level of services.

NOTED

27. CONTRACTING FOR NHS PATIENT BEDS – LOCAL AUTHORITY RESIDENTIAL BEDS AT INVERCLYDE

Mrs Hawkins provided a verbal report on progress to date on the reprovision of NHS and residential care beds at Inverclyde associated with the closure of Ravenscraig Hospital.

Following the tender which had been issued in 2010 and which had attracted no bids, a more flexible tender had been issued in 2011 which had included three sites. Following the evaluation of the tenders, Quarriers had achieved preferred bidder status and efforts were being made to try and close the outstanding financial gap.

Following discussions with Inverclyde Council it was hoped that a solution would be found to closing the current revenue gap. The impact of the timetable to date would be a delay of one year resulting in the ongoing costs of maintaining Ravenscraig Hospital falling to the NHS Board. A report was to be submitted to the Council's Committee on 27 March 2012 and it was hoped thereafter a report could be submitted to the full Council and the Quality and Performance Committee by June/July 2012. Councillor McIlwee said he had been pleased to hear this news and he was hopeful a satisfactory way forward would be found in this matter.

A further report would be submitted to the Quality and Performance Committee.

**Director,
Glasgow CHP**

NOTED

28. MINUTES OF THE CLINICAL GOVERNANCE IMPLEMENTATION GROUP: 15 DECEMBER 2011 AND 13 FEBRUARY 2012

There was submitted a paper [Paper No. 12/23] setting out the Clinical Governance Implementation Group Minutes of its meetings held on 15 December 2011 and 13 February 2012.

NOTED

29. DRAFT MINUTES OF THE QUALITY AND POLICY DEVELOPMENT GROUP: 22 FEBRUARY 2012

There was submitted a paper [Paper No. 12/24] setting out the Quality and Policy Development Group draft minutes of its meeting held on 22 February 2012.

NOTED

30. REPORT ON TRANSFER OF PRISON HEALTH SERVICES

There was submitted a paper [Paper No. 12/25] providing an update on the issues and risks following the transfer of prison health services from the Scottish Prison Service to the NHS and the commissioning of a new prison within NHS GG&C.

Mrs Hawkins advised that the responsibility to provide enhanced primary health care services to people detained in Scottish prisons transferred from the Scottish Prison Service (SPS) to the NHS Scotland on 1 November 2011. The paper set out the legislative changes required and the impact on a range of services provided within NHS GG&C from having responsibility for prison health care.

HMP Low Moss was a new purpose-build prison built in Bishopbriggs and it opened slightly earlier than planned on 12 March 2012.

On the transfer of prison health services there was a range of ongoing issues in relation to Information Management and Technology, national contracts, human resource issues including transfer arrangements, pensions, as well as outstanding and ongoing Agenda for Change banding issues. A needs assessment of prisoners' health was scheduled for completion at the end of March 2012.

Mr Winter asked about the provision of accommodation and Mrs Hawkins advised that the SPS carried responsibility for the buildings and accommodation and the NHS provided the necessary equipment for the healthcare element of the services.

Mr James would review the financial implications in relation to the part-year effect in 2011/12 and full-year effect in 2012/13 to confirm that the expected allocations are sufficient.

**Director of
Finance**

NOTED

**31. MINUTES OF THE STAFF GOVERNANCE COMMITTEE MEETING –
7 FEBRUARY 2011**

There was submitted the minutes of the meeting of the Staff Governance Committee held on 7 February 2012 [SGC(M)12/1].

Mr Winter asked about the review of productivity and efficiency with regard to administration services and in particular the reduction in administrative support from one whole time equivalent to a ratio of 0.6 whole time equivalent per manager. It had been considered that with the improvements in information technology and voice recognition and electronic data transfer this would present significant opportunities to secure efficiencies particularly in non-clinical areas. Mr Winter stated that the matter had been raised in relation to clinical groups drawing attention to delays in General Practitioners receiving discharge letters. Mr Calderwood acknowledged that there had been a reduction in the administrative and clerical posts in order to support the approved workforce plan and financial plan. It was part of the review to ensure the issues of the sufficient investment in IT, but also it was imperative that managers ensured that there were sufficient back-up services to support clinical needs including the timeous issuing of discharge letters and other patient related information.

NOTED

32. FINANCIAL MONITORING REPORT FOR THE 10TH MONTH PERIOD TO 31 JANUARY 2012

There was submitted a paper [Paper No. 12/26] from the Director of Finance setting out the Financial Monitoring Report for the 10 month period to 31 January 2012.

As at 31 January 2012 the NHS Board was reporting expenditure levels running at £0.6million ahead of budget and it was considered that the year-end break-even position would be achieved. This was reinforced by the initial indications that month 11 would show an out-turn of £0.3million in excess of budget.

Mr Winter asked about the delayed expenditure of £35million from the capital budget. It was explained that discussions had been held with the Scottish Government Health Directorate around a brokerage arrangement which would see this funding returned to the Board by supplementing the 2012/13 capital allocation.

NOTED

33. GLASGOW CITY CHP – PERFORMANCE REPORT

There was submitted a paper [Paper No. 12/27] by the Director, Glasgow Community Health Partnership (CHP) which provided background information on Glasgow CHP and setting out key financial, service, clinical and staff issues affecting the CHP. It also included a commentary on the organisational performance and overview of the challenges and risks within Glasgow CHP as well as the arrangements for the Glasgow CHP Committee and its supporting structure.

Mr Peter Daniels, Chair and Mrs Anne Hawkins, Director of Glasgow CHP gave a full presentation to Members on the background to the formation of the CHP, its Committee structure, finance arrangements, performance, and staff and partnership issues and then welcomed questions from Members.

Members asked a range of questions from the presentation and the operation of the CHP. Mr Daniels and Mrs Hawkins responded as follows:-

- Dr John Nugent, Clinical Director, had developed the GP practice performance tool and this would be shared with other partnerships within NHS GG&C.
- The Joint Partnership Board, comprising Members of the NHS Board, Councillors from the City Council and the CHP Director and Social Work Services Director continued to meet and was tasked with monitoring performance, budgets and overseeing service planning. It operated well although a more fuller engagement with all Members would be welcomed.
- The size of the CHP Committee was acknowledged as large, replicating the numbers on the NHS Board. It was considered to be effective and there were no immediate plans to consider a review of its membership as it was settling in to its new role. Seminars were planned to be introduced in the future and it was hoped that this would assist the business of the Committee and ensure full engagement of all those involved.
- Relationships between officers from the CHP and Social Work had been constructive and Social Work had restructured around the three sectors within the CHP. Tensions did arise occasionally on specific issues but these led to healthy debates and constructive discussions.

- The issue of delayed discharges was being tackled through initiatives from the Change Fund and the review underway on the Adults with Incapacity client group.

Members welcomed the excellent progress which had been achieved in under 18 months in the formation of Glasgow CHP and congratulated Mr Daniels and Mrs Hawkins. In addition they welcomed this full and comprehensive scrutiny of Glasgow CHP and the Convener thanked both for this helpful presentation and the answers they had given to the range of questions asked by Members.

NOTED

34 IMPLEMENTATION OF THE CHANGE FUND

There was submitted a paper [Paper No. 12/28] from the Director of Corporate Planning and Policy providing an update on the implementation of the Change Fund across the six Partnerships in 2011/12 and the plans and expected outcomes for 2012/13.

A national £70million Change Fund was introduced in 2011/12 to support the implementation of reshaping care for older people. This funding would continue for three years and would increase to £80million for 2012/13 and 2013/14. The Change Fund was intended to act as a catalyst for major service redesign and to enable changes to the way the total health and social care resource was used for older people, to support the policy goal of optimising independence and well-being for older people at home or in a homely setting. Change Fund plans were required to demonstrate a clear strategy to invest in anticipatory and preventive approaches to help manage demand for formal care and support carers when more older people were at home. NHS GG&C received a total allocation of £14.8million which would rise to £17.215million in the next financial year.

The critical performance measure agreed for the NHS Board was to achieve substantial reductions in the number of days beds occupied by patients who were agreed by the NHS and local authority to be ready to leave hospital. While there were indications of a downward trend overall, in several individual Partnerships towards the end of 2011, there remained a concern that the number of beds days lost was higher than the baseline year of 2009/10. Each of the six Partnerships reviewed the implementation and early impact of their Change Fund spend and commitments for 2012/13 included a reduction in bed days lost by delayed discharges by 50% against the 2009/10 baseline; address the availability of services such as physiotherapy and occupational therapy over seven days, provide consistent services and interventions and continue to develop effective Partnership approaches including robust engagement of primary care contractors and acute clinicians.

It was an evolutionary process with the overall trend remaining positive and the establishment of better relationships between acute services and the individual Partnerships. In response to a question from Mrs Spencer, Ms Renfrew advised that the six different CH(C)Ps developed their own individual plans and actions to reflect their issues and individual circumstances for their area.

The issue of carer support and respite would be discussed further at the July or September meeting of the Quality and Performance Committee.

**Director of
Corporate
Planning &
Policy**

It was emphasised that it was important that the CH(C)P Committees, whilst developing good working relationships, needed to bring about significant changes in the number of NHS bed days lost to delayed discharges and it was expected that this would be a regular feature of the Partnership Committee meeting debates.

The Convener raised the issue of the more significant increase in bed days lost within West Dunbartonshire. It was acknowledged there were difficulties with Adults with Incapacity issues. Improvements were planned and more work was required to be done on developing better incentives to achieve the targets set. The impact of the measures identified for 2012/13 were to be monitored on a monthly basis within the existing performance framework and Members noted the progress to date.

NOTED

35. REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN – JULY TO DECEMBER 2011

There was submitted a paper [Paper No. 12/29] from the Head of Clinical Governance setting out the progress against each of the recommendations highlighted in the formal reports of the Ombudsman and decision letters issues from July to December 2011.

The NHS Board received summaries of each Ombudsman report and decision letter and the recommendations contained were then subject to the development of action plans within the Acute Services Division and Partnerships. This approach had been commended by the Scottish Public Sector Services Ombudsman and there was a reporting mechanism back to the Scottish Public Health Directorate on the actions taken. The report covered two SPSPO reports and 26 decision letters together with one follow-up action from the reported period of January to the June 2011. The Convener raised the issues highlighted in the Ombudsman's overview for November 2011 in relation to vulnerability being a key theme which had arisen in three health cases. He also raised the theme identified in the December overview of communications.

Mr Calderwood indicated that Ms Crocket was picking up on the issues of vulnerability as part of the review of older people's work. In relation to communications this had been an ongoing issue for many years and was picked up in the training sessions held within Acute Services and Partnerships, where training models covered communication issues. The other concern was record keeping and the need to ensure record keeping matched that which was required by the organisation and the professional standards developed in this area.

NOTED

36. PROPERTY COMMITTEE MEETING – 10 JANUARY 2012

There was submitted a paper [Paper No. 12/32] setting out the Property Committee minutes of its meeting held on 10 January 2012.

NOTED

37. NEW SOUTH SIDE HOSPITAL AND LABORATORIES PROJECT (INCLUDING APPROVAL OF CARPARK DEVELOPMENT – SOUTH SIDE HOSPITAL)

There was submitted a paper [Paper No. 12/30] from the Project Director, Glasgow Hospitals and Laboratory Project setting out the progress against each stage of the development of the new laboratory, design development of the new hospitals, the construction of the new adult and children's hospitals and seeking approval to development of a 1000 space carpark adjacent to Hardgate Road/new children's park.

Mr Seabourne advised that works on the new laboratory and facilities management building were completed and the contractor subsequently handed the building over to NHS GG&C on 9 March 2012. A formal handover ceremony had been organised to take place on 21 March 2012. All staff transferring to the new building had been invited to attend a building induction session and 26 sessions have been organised to take place during the mid to latter part of March 2012. The Gateway Four Review for the laboratory building was held from 28 February to 1 March 2012. The Review was about the readiness for service and focussed on how ready NHS GG&C was to move into the new building and take over the running. Fourteen members of staff were interviewed and key documentation examined. The Review Team found that the delivery confidence assessment was green and the final written report was now awaited.

The Convener congratulated Mr Seabourne and his team on the handover being on time and he was looking forward to his attendance at the formal handover ceremony on 21 March.

In relation to Stage 2 for the new adult and children's hospitals, Mr Seabourne highlighted the progress in relation to the 1:50 room drawings, the fire strategy process, the mechanical and engineering systems. He also highlighted the changes to national guidance in relation to the fire code and impact on the atria in healthcare premises. The contractor had been advised of this change to the guidance and the changes requested by the project team to comply with the new guidance. Brookfield were reviewing the changes to determine the impact and cost to the Board.

Mr Seabourne gave a summary of the status of the works at Stage 3 and highlighted the remedial piling activities and the fact that the project remained on programme; the completion of the energy centre remained on programme and the community benefit programme continued to make good progress, currently exceeding the 10% targets from new entrants. A total of 151 new entrants had been employed on site and the project had taken on 35 apprentices.

Mr Seabourne took members through Table 1 – the Changes Approved and Impact on the Current Target Price, and Table 2 – Potential Compensation Events. The Convener asked about the impact of the work associated with additional guidance and fire code and Mr Seabourne indicated that any additional costs had not yet been identified as they had not determined the scope of the changes yet.

The paper submitted also included the plans for the construction of three new carparks to provide the required carpark provision as approved by Glasgow City Council as part of the planning application. These three carparks were in addition to the already completed multi-storey carpark and were as follows:-

Carpark 1 (adjacent to Hardgate Road/New Children's Park) – approximately 1,000 spaces

Carpark 2 (opposite the new hospital's A&E entrance) – approximately 300 spaces

Carpark 3 (adjacent to existing multi-storey carpark) – approximately 700 spaces

The procurement strategy for carpark 1 was highlighted in this paper and Members' approval was sought regarding the procurement recommendation and the budget allocation for carpark 1. The budget for carpark 1 was estimated at £14.4million (this incorporated works, professional fees and VAT).

The Acute Services Strategy Board (ASSB) which includes in its membership representatives from the Scottish Government Health Directorate and Scottish Futures Trust considered that there were two viable procurement options to procure the carpark 1, namely use the National framework to appoint a contractor or negotiate with current contractor. The paper set out in detail the advantages and disadvantages of both which led to the recommendation to negotiate a compensation event with the current contractor to build carpark 1. The paper also advised that the ASSB had approved the continuation of the current Technical Advisors and Technical Supervisors. Initial architectural/design services to develop the Employers Requirements will be tendered. Advice was also received from the project legal advisers and this was included within the paper submitted to Members.

Mr Winter indicated that he supported the recommendation that a compensation event be negotiated with the current on-site contractor as this reduced risk, did not interfere with the current supply chain arrangements, retained a single point of responsibility particularly in relation to any warranty issues for the sub-station carpark and kept the continuity of adviser support within the project.

The Convener asked about the costs associated with carpark 1 and procurement arrangements for carparks 2 and 3. It was explained by Douglas Ross that this was a more expensive carpark to build due to its location being on top of the new sub-station, it required a new access road and needed higher specification elevational treatment on all four sides. He also advised that carparks 2 and 3 would be procured through the Scottish Frameworks Contract at the appropriate time (therefore not negotiated tenders).

Mr Robertson indicated that the legal advice had been helpful and supported the proposal.

DECIDED

1. That the progress in relation to stages 1, 2 and 3 of the New South Side Hospitals and Laboratory be noted.
2. That the recommendation of the Acute Services Strategy Board to negotiate the compensation event with the current contractor up to the sum of £14.4million for carpark 1 at the New South Side Hospital be approved.

**Project
Director**

38. WEST TERRITORY – HUB INITIATIVE – APPOINTMENT OF A PRIVATE SECTOR DEVELOPMENT PARTNER AND ESTABLISHMENT OF HUBCO

There was submitted a paper [Paper No. 12/31] from the Head of Capital Planning providing the procurement process to select a private sector development partner to join with the 15 participants (public sector organisations including NHS GG&C) and the Scottish Futures Trust Investment Limited to establish HUBCO for the Hub West Territory and to seek approval of the appointment of Wellspring Partnership Limited as that private sector development partner. The paper and the subsequent information e-mailed to Members on the national appointments process provided the detail on the background to the Hub Initiative, programme, West HUBCO and the appointment process of the preferred private sector development partner.

Within the current territory delivery plan for West HUBCO the four following projects for NHS GG&C had been identified:-

- Gorbals Health and Care Centre
- Eastwood Healthcare Centre
- Woodside Health and Care Centre
- Maryhill Health and Care Centre

These four projects have been highlighted as a key service priority for the NHS Board and were further identified in the property and asset management system as buildings that required significant investment to upgrade or replacement. All four projects would be revenue funded with 100% revenue support for development costs funded directly from the SGHD with the facilities management costs to be provided by the NHS Board.

The corporate governance and financial implications were set out within the paper and Mr Curran reminded members that the Quality and Performance Committee or NHS Board would receive the Outline Business Case and Final Business Cases for each project for consideration and approval if acceptable.

Mr Winter asked a range of questions which Mr Curran responded to as follows:

In relation to how NHS GG&C would pay for the project, and the issues of profit redistribution dividends and returns Mr Curran advised there was an option for the NHS Board to take shareholder status in terms of an investment to this model however that was not the intention for NHS GG&C; the NHS Board could ask for particular design teams to be included within the national framework and a competitive tender process would determine who would be appointed as designers/advisers to the project and the NHS Board would draw down that expertise when required.

The Convener asked about balance sheet issues and Mr Curran advised that this would be on the NHS Board's balance sheet and Mr Calderwood described the financial arrangements around these new national arrangements.

Mr Daniels, while supporting the four projects, enquired as to the Government's processes followed in identifying these particular projects. Mr Calderwood advised that the use of the Property Asset Management System and local priorities were used in submitting schemes to the SGHD. If Members felt that any current scheme should or could be replaced with an alternative, that would be possible. He did acknowledge however that the NHS Board had not endorsed the list of schemes submitted to SGHD as it had been understood at that time the list was indicative.

Ms Dhir supported these schemes but was keen that Members were sighted on a dilapidations survey for the estate which covered the conditions of remaining properties which would provide evidence for better decision making around such priorities.

Mr Robertson reminded Members that this was the mechanism to establish the process going forward that was being considered and that the individual Outline Business Cases and Final Business Cases would be submitted to the Committee in future for consideration and approval.

DECIDED

Subject to the approval of the individual Outline Business Cases and Full Business Cases by the Quality and Performance Committee of the NHS Board the following be approved:-

- | | |
|---|---------------------------------|
| (i) the selection of Wellspring Partnership Limited as the Private Sector Development Partner (“PDSP”) in HUBCO as recommended by the West HUB Territory Programme Board (WhTPB); | Head of Capital Planning |
| (ii) the establishment of HUBCO; | Head of Capital Planning |
| (iii) the investment in HUBCO shareholding of a maximum of £30 and the provision of working capital of a maximum of £300,000. There shall be an equal shareholding for those Participants who elect to take a shareholding, and the provisions of working capital shall be split in the same proportions; | Head of Capital Planning |
| (iv) the entering into of the Territory Partnering Agreement, Shareholders Agreement and Participants’ Agreement, summary details of which are narrated in Appendix 3 to this report with delegated authority to the Chief Executive Officer to execute the same on behalf of Greater Glasgow Health Board and to grant delegated authority to the Chief Executive Officer to agree on behalf of Greater Glasgow Health Board any further non-material amendments to the Territory Partnering Agreement, Shareholders Agreement and Participants’ Agreement prior to the date of execution of the said documents; | Head of Capital Planning |
| (v) the appointment of Anthony Curran, Chair of the West HUB Territory Programme Board and Head of Capital Planning and Procurement at Greater Glasgow Health Board as the B Shareholders’ Director on the Board of HUBCO; | Head of Capital Planning |
| (vi) to note appointment of Neil Harris, HUB West Territory Programme Director as the B Shareholders’ Representative; | Head of Capital Planning |
| (vii) to note the appointment of Neil Harris, HUB West Territory Programme Director as the Lead Participants’ Representative under and in terms of the Participants’ Agreement with delegated authority to take any action, grant any approval or consent or sign any notice required in terms of the Shareholders Agreement and Territory Partnering Agreement; | Head of Capital Planning |
| (viii) the appointment of General Manager for Capital Projects as Greater Glasgow Health Board representative on the Territory Partnering Board with delegated authority to make any decisions on its behalf which require to be taken by the Territory Partnering Board pursuant to its constitution; and | Head of Capital Planning |
| (ix) to note that the Director of Finance will develop a formal Scheme of Delegation to support these arrangements; | Director of Finance |
| (x) to note the content of the Territory Delivery Plan. | |

39. DRAFT LOCAL DELIVERY PLAN – 2012/13

There was submitted a paper [Paper No. 12/33] providing Members with a copy of the draft Delivery Plan - 2012/13 as submitted to SGHD and that the final Local Delivery Plan will be presented to the Committee at a later date.

NOTED

40. HEALTH PROMOTING HEALTH SERVICE; ACTION IN HOSPITAL SETTING

There was submitted a paper [Paper No. 12/34] providing the proposed delivery and reporting arrangements for the Health Promoting Health Service; Action in Hospital Setting Circular from SGHD.

A report would be submitted to the Committee on a regular basis on the progress.

NOTED

41. PENSIONS REFORM

Mr Calderwood advised Members of the intended targeted industrial action to be undertaken by Unison members on 27 March 2012 in relation to strike action by their members within the finance and procurement areas.

NOTED

42. MS R DHIR MBE

The Convener advised Members that this was the last meeting Ms Dhir would be attending as her term of appointment ended on 31 March 2012. He took this opportunity to thank Ms Dhir for her significant contribution to the work of the then Performance Review Group and the new Quality and Performance Committee. He had enjoyed her contributions across a range of issues considered by the Committee and wished her well for the future. A lunch with Members had been arranged for 2 April 2012.

43. DATE OF NEXT MEETING

9.00 a.m. on Tuesday, 15 May 2012 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:55 p.m.

DRAFT

QPC(M)12/03
Minutes: 44 - 63

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 15 May 2012 in the
Board Room, J B Russell House
Gartnavel Royal Hospital, 1055 Great Western Road,
Glasgow, G12 0XH**

P R E S E N T

Mr I Lee (Convener)

Mr I Fraser
Mr D Sime

Mrs P Spencer
Mr K Winter

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

Dr J Armstrong (to Minute 59)
Mr R Calderwood
Ms R Crocket

Mr P James
Dr R Reid
Mr A O Robertson OBE

Rev Dr N Shanks

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

Mr A Crawford	..	Head of Clinical Governance (to Minute 51)
Mr I Finlay	..	Associate Medical Director, Surgery and Anaesthetics (to Minute 42)
Mrs J Grant	..	Chief Operating Officer - Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Ms P Mullen	..	Acting Head of Performance and Corporate Reporting (to Minute 54)
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy
Mr D Ross	..	Director, Currie & Brown UK Limited (for Minute No. 59)
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (for Minute No. 59)

ACTION BY

44. APOLOGY

Apologies for absence were intimated on behalf of Dr C Benton MBE, Ms M Brown, Mr P Daniels OBE and Mr B Williamson.

Following the outcome of the recent Local Authority elections, the Convener recorded his appreciation of the contributions of the Local Authority members, Councillors Ronnie McColl, Joe McIlwee and Douglas Yates, to the work of the Quality and Performance Committee.

45. MINUTES OF PREVIOUS MEETING

On the motion of Mr K Winter and seconded by Mrs P Spencer, the Minutes of the Quality and Performance Committee meeting held on 20 March 2012 [QPC(M)12/02] were approved as a correct record.

NOTED

46. MATTERS ARISING

- (a) Rolling Action List

NOTED

- (b) Western Infirmary – Site B: Update

In relation to Minute No. 21(c) – Western Infirmary – Site B: Update, Mr Calderwood advised that negotiations were continuing with the University of Glasgow in an attempt to complete the sale of Site B by 30 June 2012. The University Court would consider the Heads of Agreement at a meeting next week.

Negotiations also included the housing of University staff in appropriate accommodation in the New South Side Hospital, a monetary contribution and following on from this providing embedded space for teaching and research at the New South Side Hospital. There were also discussions about the possibility for a joint academic and post-graduate building on the same site.

Mr Calderwood would provide a further update on both issues highlighted above to the Committee.

CEO

NOTED

- (c) Transfer of Prison Health Services: Financial Allocation

In relation to Minute No. 30 – Transfer of Prison Health Services – Mr James reported that the NHS Board allocation had included £4.4m in 2012/13 for managing the prison health services. He would report back to the Committee in the autumn as part of the Financial Monitoring Report, on the adequacy of the funding.

**Director of
Finance**

NOTED

47. SURGICAL PROFILE AND DIRECTORATE PRESENTATION

There was submitted a paper [Paper No. 12/36] by the Associate Medical Director, Surgery and Anaesthetics, setting out the NHS Board's response to Healthcare Improvement Scotland (HIS) and the Information Services Division (ISD) Surgical Profile which presented a range of clinical indicators from various national data sources. This was the third Surgical Profile and the intention was to assist NHS Boards to continuously improve the quality, safety and effectiveness of surgical care. Mr Finlay, Associate Medical Director, gave a presentation to Members on the outcome of this external scrutiny, the impact on NHS GG&C and the actions being taken to address the report's findings. The presentation included information on the work and responsibilities of the Surgery and Anaesthetics Directorate.

Members asked a range of questions on the presentation and Mr Finlay responded as follows:-

- The number of elective aortic aneurysm procedures carried out took account of other possible radiological interventions
- The benefits of non-elective cholecystectomy procedures was recognised but not achievable under the present design of services across the acute hospitals in NHSGG&C. A move to a single site for non-elective cholecystectomy procedures would be considered as part of the move to the new South Side Hospital or as part of the review of clinical services: Fit for the Future Strategy. There were strong clinical benefits in this model and it would be one of the options to be considered by the NHS Board when considering the re-design of clinical services.
- The Consultants Appraisal and Re-Validation processes were incremental processes which were bringing about improvements to patients through improved performance. The inclusion of patient and colleagues' feedback every five years would bring a further patient focus element to the process.
- The provision of standardised basic instrumentation packs for surgeons had proven helpful.

The Convener thanked Mr Finlay for his most interesting and informative presentation and for answering Members' questions in an open frank way.

NOTED

48. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No. 12/37] from the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGG&C's performance in context of the Quality Strategy.

Of the 33 measures which had been assigned a performance status based on their variance from trajectories and/or targets, 23 were assessed as green; four as amber (performance within 10% of trajectory) and six as red (performance 10% outwith meeting the trajectory). The areas where improvement was required were:-

- New Out-Patient Did Not Attend Rates
- Faster access to specialist services – child and adolescent mental health
- Access to psychological therapies
- Acute bed days lost to delayed discharge
- Delayed discharge
- Sickness absence

An exception report had been prepared for each of the above measures which had been rated as red in order to provide the Committee with the assurance that action was underway to address performance.

In relation to violence and aggression incidents it was confirmed that the Health and Safety Forum through the Violence Reduction Group reviewed incidents on a regular basis and had developed a Violence and Aggression Strategy to assist in this area. It was agreed that the Director of Human Resources would provide a report to the next meeting of the Committee on the processes and actions taken in relation to reviewing violence and aggression incidents.

**Director of
Human
Resources**

In relation to faster access to specialist services – child & adolescent and mental health services - the Director, Glasgow CHP provided an update on the plans to meet the target of a maximum wait of 26 weeks by March 2013. Performance had improved in wait times from 57 weeks to the March 2011 figure of 48 weeks. A trajectory was in place and managers were using a demand and capacity tool, looking at job planning, referrals and assessing possible interventions from other services in order to achieve the waiting time target set for March 2013. Progress would be monitored through the integrated report.

Members remained concerned at the New Patient Did Not Attend performance which was 13.1% in the period January to December 2011 and in 2010/11 had been 13.9% across the NHSGG&C. This was made up of 7.4% from the least deprived patients to 19.4% in the most deprived areas. In addition to the production of the strategy – “Managing Referrals into Acute Services” – which covered a joint approach between Acute Services and Partnerships to manage the flow of patients across health care systems, Mrs Grant advised on the pilot which had been utilised within NHS24 on patient-focused booking. This system would be operated within a specific area within Acute Services with the plan to target it at the hard to reach patients in the hope that some benefits will flow from the outcome of the pilot. She confirmed that sensitive overbooking at some clinics was taking place in an effort to reduce the inefficiency highlighted by patients not attending treatment clinic appointments.

The sickness absence rate for March 2012 was 4.94% and Members had discussed on previous occasions the areas of short-term absences and long-term absences and the strategies and plans in place to bring about improvements to both. Managers strive for a balance between pursuing service efficiency and responding compassionately to individual circumstances affecting staff. It was agreed that the Director of Human Resources would submit a report to the Committee on the range of processes in place to manage the sickness absence within the NHSGG&C and in particular to highlight the efforts made to manage stress in the workplace.

**Director of
Human
Resources**

NOTED

49. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) – MAY 2011

There was submitted a paper [Paper No. 12/38] by the Medical Director focussing on progress in the adult care programme and on the paediatric programme.

The SPSP approach focussed on improving safety by increasing the reliability of health care processes within acute care. This was achieved by front line teams testing and establishing a more consistent application of clinical or communication processes. The two over-arching improvement aims were:-

- Mortality – 15% reduction
- Adverse events – 30% reduction

The National SMR had reduced to 0.92% and whilst this was a significant reduction it was not generally expected that the national aim would be fully met by the end of 2012. In addition the measurement plan for the reduction of adverse events, based on the global trigger tool, had been unsuccessful across NHS Scotland with detection rates well below predicted levels.

The report set out a summary of those clinical elements in the programme, along with the prediction of the NHS Board’s likely achievement levels for spreading the element to 90% of all applicable areas by December 2012. Good progress was

predicted in ten areas with a further five areas likely to achieve between 50% - 90% spread and two areas likely to achieve under 50% - these being diabetic and glucose control (peri-operative) and medicines reconciliation. The report set out a response plan for both.

In relation to the paediatric programme the majority of requirements had been met however of the ten areas not met, there have been associated problems in either the measurement or redesign and the paper set out the actions to address each one.

Dr Armstrong indicated that this report was predominately a stock-taking exercise of what had been achieved and the areas at risk, which allowed the NHS Board to focus on the areas not currently being achieved.

Dr Reid asked about the electronic patient record system in relation to medicines reconciliation. Mr Calderwood replied that he was chairing a national group on this matter and he was due to report on his recommendations to NHS Scotland by the end of the year. In addition, there was local consensus on the importance of accelerating the roll-out of medicines reconciliation. Acute Services were reviewing their Directorate plans to identify opportunities for the more rapid implementation with a report being submitted in June to the Acute Services Division Clinical Governance Forum. A further update on actions and predictions would be submitted to the Quality and Performance Committee thereafter.

**Medical
Director**

NOTED

50. INFECTION CONTROL SERVICE – HAI REPORTING TEMPLATE – APRIL 2012

There was submitted a paper [Paper No. 12/39] by the Medical Director covering the Board-wide infection prevention control activity. As previously agreed the report was on an exception reporting basis only as a full report was submitted to each NHS Board meeting.

The report indicated that the most recent validated results available for October – December 2011 demonstrated a Staphylococcus Aureus Bacteraemias (SAB) rate of 0.296 per 1000 acute occupied bed days against the revised 2013 HEAT target of 0.26 cases.

The rate of Clostridium Difficile infection for October – December 2011 was 0.21 per 1000 occupied bed days and this was well below the revised 2013 HEAT target of 0.39.

In relation to compliance with hand hygiene, the bi-monthly audit for November – December 2011 was 92% which was slightly down on previous months.

In relation to surgical site infection surveillance, within the period of October – December 2011, the NHS Board was below or equal to the national average for identified procedure categories.

Dr Armstrong provided members with an update on the recent outbreak of a Norovirus bug within Glasgow Royal Infirmary and more recently the Royal Alexandra Hospital. She reported that eight wards had been closed at the Royal Alexandra Hospital and outbreak control procedures were being followed and it was hoped that some wards would be re-opened shortly.

In addition she reported on an infection within the renal unit at the Western Infirmary. Daily outbreak control team meetings were being held and additional cleaning, hand hygiene and environmental issues were underway to reduce the infection.

Lastly, she reported on the closure of ward 10 at the Victoria Infirmary from 20 – 23 April following two patients being identified as having multi-resistant acinetobacter baumannii. Infection control measures were in place including twice daily cleaning of the ward and enhanced screening had been agreed which would include weekly screening of all patients.

NOTED

51. CLINICAL RISK MANAGEMENT REPORT: SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS

There was submitted a paper [Paper No. 12/40] by the Medical Director on adverse clinical incidents. The reporting of adverse clinical incidents had been displayed in two separate charts in order to highlight the position within Acute Services and separately within Partnerships.

In relation to Acute Services the clinical incidents were routinely reviewed at each meeting of the Clinical Governance Forum. For Partnerships the vast majority of cases were related to mental health and it was reported there was an ongoing review of significant clinical incident reporting and alignment in future to the revised clinical governance arrangements within Partnerships.

Dr Armstrong provided members with the detailed summary on ongoing forthcoming Fatal Accident Inquiries and of a recent death and answered members' questions in relation to specific cases.

NOTED

52. HEALTH CARE IMPROVEMENT SCOTLAND – ANNOUNCED INSPECTION REPORT – CARE OF OLDER PEOPLE IN ACUTE HOSPITALS

There was submitted a paper [Paper No. 12/41] by the Nurse Director advising that the final inspection reports from Health Care Improvement Scotland (HIS) for the announced inspections on the care of older people in acute hospitals for the Western Infirmary and Royal Alexandra Hospital had been received. The Cabinet Secretary for Health, Well-being and Cities announced that HIS would carry out the new programme of inspections on the care of older people in acute hospitals and the purpose of this paper was to inform the Committee on the outcome of the visit undertaken to the Western Infirmary from 21-23 February and Royal Alexandra Hospital from 14-15 March 2012.

The inspections focused on three national quality ambitions for NHS Scotland, which ensure that the care provided to patients was person-centred, safe and effective. Inspections were to ensure that older people were treated with compassion, dignity and respect and would focus on one or more of the following areas:-

- Dementia and cognitive impairment
- Falls prevention and management
- Nutritional care and hydration
- Preventing and managing pressure ulcers

Both reports were available on HIS's website along with the NHS Board's improvement plans. Emerging themes from both inspections was the need for early assessment of patients with cognitive impairment.

It was also reported that an inspection was undertaken between 2 – 4 May 2012 at Glasgow Royal Infirmary and the final report was awaited. The outcome would be submitted to the next available Quality and Performance Committee meeting. In relation to the question from a member, Mr Calderwood advised that he, Mrs Crocket and Mrs Grant were seeking a meeting with the inspectors to discuss the draft report and the inspection process.

Nurse Director

NOTED

53. ADDITIONAL COMMUNITY CARE PACKAGES

There was submitted a paper [Paper No. 12/42] by the Director of Corporate Planning and Policy on the age-differentiated approach to the provision of NHS input to patients living in the community who had additional community care needs. The paper proposed a revised and consistent approach which would ensure the Board was not discriminating on the basis of age.

The paper indicated that the Corporate Management Team had previously considered policy risks and costs of community care packages and had taken a view that the NHS input on funding should be limited to core community services (eg district nursing). The paper extended that approach to include children with a particular focus on home ventilation where the approaches to adults and children were the most divergent. There were broadly two different systems in operation within NHS GG&C covering children and adults. Due to these differential arrangements and increasing survival of disabled children, recent cases had highlighted concerns about transition from children's to adult services and the confusion the differential approach created.

The plan was to shift all new patients to a consistent approach for children and adults ready for discharge from hospital and the consistent approach for patients who required home invasive ventilation. The NHS contribution would cover the provision of standard community services with specialist advice, support and training where required. It would not extend to the provision of care workers to support the individual at home. It was recognised that agreement was required on what age current support to patients would move away from the extended NHS service and to consider the appropriate issues to work through for staff who currently provide this service.

NOTED

54. ANALYSIS OF LEGAL CLAIMS – MONITORING REPORT (AND YEAR END REVIEW)

There was submitted a paper [Paper No. 12/43] by the Head of Board Administration on the handling and settlement of legal claims within NHS Greater Glasgow and Clyde for 2011/2012.

The Monitoring Report highlighted the number and value of claims settled in 2011/12 with comparative figures for the previous year. Information was given on outstanding claims together with a breakdown of new claims notified in the last year and the proportion falling to each Acute Directorate and CH(C)P.

It was agreed that future reports should include the Board's annual contribution to the Clinical Negligence and Other Risks Scheme (CNORIS) in order to see the full annual cost to the NHS Board of settling legal claims.

**Head of Board
Admin**

NOTED

55. REVIEW OF ASPECTS OF WAITING TIMES MANAGEMENT

There was submitted a paper [Paper No. 12/44] by the Chief Operating Officer setting out the implications for NHS GG&C following the publication of the PriceWaterhouseCoopers (PWC) report on "Review of Aspects of Waiting Times Management at NHS Lothian". A number of areas of concern were highlighted in the report which was published on 19 March 2012. These were:-

- Use of periods of unavailability (particularly social unavailability)
- Reporting of unavailability
- Trakcare system
- Working practices and guidance
- Culture and governance

The Scottish Government Health Directorate had sought clarification on the practices adopted by the NHS Board in Scotland on issues of unavailability. Unavailability was characterised as follows:-

- (i) Medical unavailability
 - where a patient had a clinical condition/co-morbidity which prevented them from progressing to their treatment pathway
- (ii) Social unavailability
 - where a patient had a personal issue/engagement which prevented them from being available for an appointment or treatment;
 - where a patient elected to wait for a specific location or consultant rather than accepting the first available appointment or treatment slot.
- (iii) Other
 - where a patient was subject to patient-focused booking process and had not responded to a first letter.

NHS GG&C provided SGHD with information on current practice in the use of Unavailability Status Codes and Appendix B of the paper provided the position within the NHS Board as at 31 March 2012.

The Acute Services Division had reviewed the position within their Directorates and had confirmed at a high level that waiting lists were being managed in compliance with the required New Ways guidance including the use of Unavailability Codes, with the exception of a small number of patients in neurosurgery. The detail had been incorporated into Appendix A of the paper.

The paper highlighted that SGHD had advised that all Boards must instruct an internal audit of their waiting time arrangements in 2012/13. The outcome of the audit was also to be reported to SGHD. In addition, Audit Scotland were considering methodology in terms of undertaking a review of waiting times management within four NHS Boards within Scotland.

The NHS Board received high level reports on performance against waiting time guarantees at each meeting. The Corporate Management Team received a monthly report which provided more detail on the unavailable position and highlighted three-month trends. Lastly, waiting times management was also a key element of the Organisational Performance Review process. A review was underway to ensure that the NHS Board was alerted to indicators which may merit further examination or explanation.

In responding to the practicalities of a patient being added to the waiting list or a decision taken on an Unavailability Status Code, Mrs Grant explained the process and the roles undertaken by the consultant, the secretary and the waiting times administrative staff. In relation to the recent review of Secretary/PA services, it was explained that the role of the Secretary/PA together with the waiting times administrative staff were more focused on this area of work and more routine duties including typing was being handled by a typing pool arrangement.

Mr Sime commented that the outcome of the PWC report was wider than just waiting times management and there was an issue of culture which he hoped that the Corporate Organisational Development Group would review and make recommendations. It was confirmed that the OD Group were reviewing these matters with the intention of submitting a report to the Corporate Management Team and ultimately reporting the outcome to Staff Governance/Quality and Performance Committee.

**Director of
Planning and
Policy**

The Convener asked how the use of unavailability codes was monitored. Mrs Grant explained that there were clear rules and definitions given to the waiting times administrative staff and monitoring and review took place at the high level in terms of the numbers and trends within each area/code.

Members welcomed the detailed report, the reporting line for both sets of Auditors to the Audit Committee and steps which were taken within NHS GG&C to implement the findings and recommendations of the waiting times management report.

NOTED

56. REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN – JANUARY TO MARCH 2012

There was submitted a paper [Paper No. 12/45] from the Head of Clinical Governance setting out the progress against each of the recommendations highlighted in the formal report of the Ombudsman and the decision letters issued from January to March 2012.

The NHS Board received summaries of each Ombudsman Report and Decision Letters and the recommendations contained were then subject to the development of action plans within the Acute Services Division and Partnerships. This approach had been commended by the Scottish Public Sector Services Ombudsman. The paper covered two SPSO reports and 15 Decision Letters.

The Head of Board Administration advised that one recommendation within Acute Services and one recommendation within a dental practice had not yet been completed and the outcome would be reported in the next report to the Committee.

**Head of
Clinical
Governance**

NOTED

57. FINANCIAL MONITORING – YEAR END 2011/12

The Director of Finance advised members that subject to Audit Scotland's review of the Annual Accounts, the year end for 2011/12 was likely to see expenditure being £0.3m under budget. The Audit Committee would meet on the 5th and 19th June to review the Annual Accounts' process and the Annual Accounts would be presented to the NHS Board on 26 June 2012 for approval.

**Director of
Finance**

The Director of Finance confirmed that he was indeed looking at budget phasing for 2012/13 to ensure a more relevant monitoring of the Board's financial position on a monthly basis including the reporting on savings plans and contingencies.

**Director of
Finance**

NOTED

58. DRAFT FINANCIAL PLAN 2012/13

There was submitted a paper [Paper No. 12/46] from the Director of Finance seeking approval to the 2012/13 Financial Plan, pending ratification at the NHS Board meeting on 26 June 2012.

The Board had submitted a draft Financial Plan to SGHD in February 2012 as required as part of the Local Delivery Plan submission. An update was provided in March 2012 however at that stage the Cost Savings Plan had not been finalised. Members had been involved in NHS Board Seminar discussions in developing and shaping the Financial Plan and Cost Savings Plan over the last few months and the draft Financial Plan reflected the outcome of these discussions. The paper set out the key elements of the Financial Plan, highlighting key assumptions and risks and explained how it was proposed to address the cost savings challenge which the NHS Board faced in order to achieve a balanced financial out-turn in 2012/13.

SGHD had confirmed the headline funding uplift for 2012/13 of £46.2m – 2.4%. A savings target of 3% had been set for 2012/13 and taking into account funding issues, cost drivers and new service commitments, the savings required in 2012/13 was £59m. The Director of Finance took members through the paper and highlighted pay-cost growth, prescribing, energy costs, capital charges growth, service commitments and the specific cost savings target for each Acute Directorate.

The Director of Finance responded to members' questions by giving the breakdown of the £7m set aside for general provisions to cover known risks and also described the process of the national negotiations around the uplift for resource transfer arrangements.

DECIDED:

- That the Financial Plan at 2011/12 would be approved pending ratification at the NHS Board meeting on 26 June 2012.

59. NEW SOUTH SIDE HOSPITAL AND LABORATORIES PROJECT

There was submitted a paper [Paper No. 12/47] from the Project Director of Glasgow Hospitals and Laboratory Project setting out the progress against each stage of the development of the new laboratory, design development of the new hospitals and construction of the new adult and children's hospitals.

The laboratory building was handed over to the Board on 9 March 2012 and a formal handover ceremony took place on 21 March 2012. The Project Commissioning Team have been managing staff inductions, installation of Group 3 and 4 equipment, installation of transferred equipment, day to day running of the building and the interface with the contractors over any defects. The Migration Plan was underway and by May 2012 the following services had moved in – UK NEQAS – from the Victoria Infirmary; molecular genetics from Yorkhill, paediatric virology and molecular from Yorkhill, mycology from Yorkhill and molecular haematology from Yorkhill. The next services to move in would be the mortuary and post-mortem services from the Southern General and Yorkhill and all pathology departments. The city morgue was planned to be on location by 5 June 2012. In addition the biochemistry and haematology departments would move in in late May/early June.

In relation to Stage 2 - new Adult and Children's Hospital, good progress continued to be made in the design of layouts and systems for the two hospitals. Work had commenced on identifying the larger pieces of equipment for transfer to the new hospitals and the specifications for equipment in specialist areas; this would be taken forward with significant user input.

The Chief Operating Officer had formally approved the Ophthalmology department's request for a treatment room to be transferred into a clean room and the contractors have been advised to carry out this conversion. In relation to the new fire guidance issued by Health Facilities Scotland, the designers were reviewing the guidance to determine any changes which may be required to be made to the design together with any associated costs.

A summary of the Stage 3 works was provided covering the slip cores, the completed link tunnel between the laboratory facility and the new hospitals, and the basement tunnel work was well underway. The paper set out the fit-out/mechanical installation progress together with the external walling/cladding and provided images of the progress for members.

Mr Seabourne took members through the process in relation to the approved Carpark 1 Project. A voluntary ex-ante transparency notice had been formally published in the official Journal of the European Union on 6 April and it was decided to await a three month period from the date of issue of the notice to see if any concerns or enquiries were raised. Following a tendering process a firm of architects had been appointed on 25 April 2012 to prepare the Stage D design and submission of a planning application for Carpark 1. An indicative programme was provided covering the design processes, submission of the planning application, negotiations with the contractor and the intention to seek the Committee's approval to a full business case for Carpark 1 in September 2012.

**Project
Director**

The Community Benefits Programme continued to make good progress with a total of 171 new entrants being employed on the site including 47 apprentices. An additional 87 jobs had been filled in partnership with Glasgow Regeneration Agency. Work with schools continued and pupils were undertaking visits to the new laboratory and an independent learning project with six secondary schools in South West Glasgow had been completed in April 2012. Members were delighted with the progress shown under community benefits and in particular the employment of 47 new apprentices. Further consideration would be given as to how best to publicise this success and Mr Seabourne explained that the Community Engagement Officer for the project was well connected with local community councils and other groups in ensuring they were fully aware of the progress and intentions of the new South Side Hospitals project.

**Project
Director**

Mr Ross took members through the change control process, potential compensation payments and overall budget. The Convener enquired about the £300,000 in relation to adverse weather conditions during late 2011. It was explained that there had been a series of isolated one in ten year weather events and cumulatively they had resulted in a compensation event due under the conditions of the contract.

NOTED

60. MINUTES OF THE QUALITY AND POLICY DEVELOPMENT GROUP – 23 APRIL 2012

There was submitted a paper [Paper No. 12/48] setting out the Quality and Policy Development Group minutes of its meeting held on 23 April 2012.

NOTED

61. MINUTES OF THE STAFF GOVERNANCE COMMITTEE – 3 APRIL 2012

There was submitted a paper [Paper No. 12/49] setting out the Staff Governance Committee minutes of its meeting held on 3 April 2012.

NOTED

62. MINUTES OF THE CLINICAL GOVERNANCE IMPLEMENTATION GROUP – 16 APRIL 2012

There was submitted a paper [Paper No. 12/50] setting out the Clinical Governance Implementation Group minutes of its meeting held on 16 April 2012.

NOTED

63. DATE OF NEXT MEETING

9.00am on Tuesday 3 July 2012 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 0XH

The meeting ended at 12.05pm