

NOT APPROVED AS A CORRECT RECORD

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 20 September 2011 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	Mr D Sime
Ms M Brown	Mrs P Spencer (to Minute 33)
Ms R Dhir MBE	Mr K Winter

OTHER BOARD MEMBERS IN ATTENDANCE

Mr R Calderwood	Mr P James
Dr B Cowan (to Minute 34)	Mr A O Robertson OBE
Ms R Crocket (to Minute 38)	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 32)
Mrs J Gibson	..	Head of Performance and Corporate Reporting (to Minute 38)
Mrs J Grant	..	Chief Operating Officer - Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Mr N McGrogan	..	Head of Community Engagement and Transport (for Minute 39)
Ms J Murray	..	Director, East Renfrewshire CH(C)P (to Minute 24)
Ms K Murray	..	Director, East Dunbartonshire CHP (for Minute 22(c))
Mr I Reid	..	Director of Human Resources
Dr S Rodger	..	Associate Medical Director, Regional Directorate (to Minute 23)
Mr D Ross	..	Director, Currie & Brown UK Limited (for Minute 39)
Mr J Rundell	..	Audit Scotland
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (for Minute 39)

ACTION BY

20. WELCOME AND APOLOGIES

The Convener welcomed Ms Helen Russell, Audit Scotland, who was attending her first meeting of the Committee. She was taking over the external audit role from Mr Jim Rundell. The Convener wished Mr Rundell well with his new responsibilities and thanked him for his contribution to the NHS Board's work over the last 5 years.

Apologies for absence were intimated on behalf of Mr P Daniels OBE, Mr I Fraser, Cllr. R McColl, Cllr. J McIlwee, Mr B Williamson, and Cllr. D Yates.

21. MINUTES OF PREVIOUS MEETING

On the motion of Ms R Dhir and seconded by Mr K Winter, the Minutes of the Quality and Performance Committee meeting held on 5 July 2011 [QPC(M)11/01] were approved as a correct record.

22. MATTERS ARISINGa) Rolling Action List

At the Convener's request, Mr Calderwood provided Members with an update on Blawarthill and Linwood Health Centre. As had been reported at the August Board meeting, discussions were continuing with Glasgow City Council over the possible transfer of land for the provision of a Care Home. A further progress report would be submitted to the NHS Board by the end of the year.

**Director of
Corporate
Planning &
Policy**

Renfrewshire Council had asked the retailer to submit a revised planning application to take account of the NHS Board's concerns about access and parking. It was recognised, however, that any future development of Linwood Health Centre would be compromised on the current site as there was no expansion possible.

NOTEDb) Mental Welfare Commission Report – Starved of Care: NHS GG&C Report

In relation to Minute 8 – Mental Welfare Commission (MWC) Report – Starved of Care – there was a paper submitted [Paper No. 11/17] by the Chief Operating Officer – Acute Services Division and the Director, Glasgow Community Health Partnership setting out the self-assessment which had been completed against the Report's recommendations. The accompanying Action Plan highlighted the improvements required, the identified lead officers and timescales for completion.

Mrs Spencer made reference to the Mental Health Strategy which was currently out to consultation until January 2012 and the need to ensure that the physical health care needs of the severely mentally ill be taken into account, particularly as a result of the MWC Report. Mrs Hawkins agreed to pick this up as part of the Mental Health Strategy and the National Dementia Strategy for Scotland.

**Director,
Glasgow City
CHP**

Members were pleased to note the progress and steps being taken as a result of considering the recommendations of the MWC Report – Starved of Care.

DECIDED:

That the Action Plan be noted and that a follow-up report be submitted to the March 2012 meeting of the Committee.

**Chief
Operating
Officer –
ASD/Director,
Glasgow CHP**

c) Dental Hospital – Flood Damage: Progress

In relation to Minute 13 – Dental Hospital – Flood Damage – there was a paper submitted [Paper No. 11/18] which provided an update on the work to reinstate the flood damaged areas within the Dental Hospital and the progress on the negotiations with the Contractor's insurers for recovery of any allowable sums expended.

The necessary works had been completed and the areas re-occupied by the University of Glasgow, NHS National Education Services and post-graduate teaching were now fully operational with only the main entrance door to be replaced during September 2011. The works had been progressed on the basis of revised estimates, tendered costs and equipment assessments which had resulted in the costs of reinstatement being reduced with an out-turn cost expected to be £467,000.

The NHS Board had made a claim against the contractors for these damage reinstatement costs. Separate independent expert reports had been commissioned by the NHS Board and Loss Adjustors in order to establish the cause of, and liability for the water escape and subsequent damage. These negotiations were ongoing.

In response to Members' questions, Mrs K Murray confirmed that the Dental Hospital Estates staff had agreed to use of the existing filter unit as a temporary measure until the new filter unit had been delivered on site. The Contractor took responsibility for that removal and installation. In addition, Mrs Murray confirmed that the cost of £467,000 included the costs for the independent expert reports.

NOTED

23. ORGAN DONATION ANNUAL REPORT

There was submitted a paper [Paper No. 11/28] from the Medical Director on the Organ Donation Annual Report – 2010/11 and the NHSGG&C audit of potential organ donors as at 1 July 2011.

Dr Stuart Rodger, Associate Medical Director, Regional Directorate took Members through the Annual Report and highlighted the role of the Organ Donation Committee (Chaired by Mr R Cleland) as reviewing and re-organising clinical practice related to organ and tissue donation in line with the recommendations of the Organ Donation Task Force.

In addition to the Organ Donation Committee, an Organ Donation Clinical Executive Implementation Group was set up under the Chairmanship of Dr Stuart Rodger. Eight Clinical Leads had been identified and appointed to this Group for all Intensive Care Units in NHSGG&C and they meet regularly with their hospital Specialist Nurses for Organ Donation to audit and report on Intensive Care Unit deaths, as well as deaths in Accident and Emergency and Stroke Units.

A work plan has been established to develop organ donation activities and the Director of Corporate Communications assisted with the publicity to promote opportunities for organ donation.

Dr Rodger advised that the Audit of Potential Organ Donors provided a summary of data relating to potential and actual organ donors as recorded by NHS Blood and Transplant via the Potential Donor Audit and the UK Transplant Registry for NHSGG&C. The report facilitated case-based discussion about organs by the Organ Donation Committee.

In response to a question from Ms Dhir, Dr Rodger confirmed that there was an Organ Sharing Scheme operating UK-wide. He also confirmed that evidence suggested that younger members of the population were more likely to register for organ donation but much still needed to be done to see a significant increase in the number of organ donors.

Clinical access to the Registry was available via a computer link but it was possible that despite a person being registered, the next of kin or family could still refuse to give permission to remove an organ for donation.

NOTED

24. EAST RENFREWSHIRE CH(C)P PERFORMANCE REPORT

There was submitted a paper [Paper No. 11/19] by the Chair and Director, East Renfrewshire CH(C)P providing background information on East Renfrewshire CH(C)P and setting out key financial, service, clinical and staff issues affecting the CH(C)P and a commentary on organisational performance and an overview of challenges and risks.

The Convener advised that this was the first scrutiny of a CH(C)P which had been undertaken by the new Quality and Performance Committee and he was keen to receive members' feedback on the process followed in order to consider any improvements for future reviews of performance of the CH(C)Ps

Mrs J Murray, Director, East Renfrewshire CH(C)P, started by apologising that the Chair, Cllr. D Yates had, unfortunately, been unable to attend this morning's meeting. He had been asked to meet with the Cabinet Secretary for Health, Wellbeing and Cities Strategy.

Mrs Murray gave a short presentation to Members on the key performance areas and challenges facing East Renfrewshire CH(C)P and then welcomed questions from the Committee.

Members asked a range of questions from the presentations and operation of the CH(C)P. Mrs Murray responded as follows:-

- Leadership – the challenge of leading staff across two organisations was recognised; however, strong and visible management was important and good staff engagement including regular team briefing were a priority. A Roadshow for staff had been planned for later in the year.
- Shifting the Balance of Care – the CH(C)P was part of a national pilot in re-launching home care services for older people; community budgets were allowing services to be wrapped around people and Social Work had been aligned to five GP practices to date with the plan to roll that out to all fifteen GP Practices later. Monitoring of those over 65-year-olds with two or more re-admissions was showing a reduction.
- Change Fund – working closely with hospitals on discharges; getting home care packages right; seeking alternatives to hospital; building community capacity and working more with community groups and volunteers had been helpful. In addition, engaging direct with carers and the voluntary sector and re-shaping day care services with older people's teams had assisted.
- Budgetary pressures – restructuring opportunities were considered which included a review of back-office services; there were spend-to-save opportunities; a desire to provide integrated and seamless services to the patient thus avoiding unnecessary duplication.

Members welcomed this full and comprehensive scrutiny of East Renfrewshire CH(C)P and thanked Mrs Murray for her helpful presentation and answers to the range of questions asked. It was recognised that this was a mature integrated CH(C)P in its 6th year and many achievements had resulted from the integration and joined up services for patients.

The CH(C)P Committee worked well and the Convener, as a Member of East Renfrewshire CH(C)P Committee, commented about how impressed he had been that a Committee with a membership of such diverse backgrounds was able to work in such an integrated way with a clear goal of bringing about successful improvements in services for patients.

NOTED

25. SCOTTISH PATIENT SAFETY PROGRAMME

There was submitted a paper [Paper No. 11/20] by the Medical Director setting out the progress in the implementation of the Scottish Patient Safety Programme (SPSP) reflecting the activity within NHSGG&C during July and August 2011.

Dr Cowan reminded Members that the aim was to achieve full implementation of the core programme within NHSGG&C – Acute Services by the end of December 2012. It had previously been an aspiration that Mental Health Services would also be involved; however, the national support to SPSP has not yet delivered its outline objectives meaning that a formal mental health programme was not yet possible. Dr Cowan advised, however, that a Paediatrics Safety Programme was now well under way and Members endorsed the revised aim from that of creating start-up to one of aligning the national medium term objectives for Paediatrics.

A visit by the National SPS Team in June and a recent visit by Swedish colleagues had provided good and positive feedback on the progress being achieved by NHSGG&C. An Action Plan was now being developed in order to resolve any outstanding issues which can now be picked up from the change in interpretation to some elements of the programme and this should, hopefully, lead to confirmation of progress to level 3.5 in the fairly near future.

Mrs Spencer asked about the difficulties associated with releasing clinical staff for the next SPSP conference (Learning Session 8 on 3rd and 4th October 2011). Dr Cowan advised that there has been encouragement for middle managers to also attend but there was slightly less enthusiasm due in some part to the repetitive nature of the sessions.

Dr Cowan, in response to a question from Ms Dhir, advised that patients self-administering medicines were still carried out in a supervised model.

Mrs Spencer asked about the difficulties with including Mental Health Services and Mr Crawford, Head of Clinical Governance, advised that national evidence-based bundles of care still remain untried and untested and, therefore, not suitable at this stage for this programme.

NOTED

26. INFECTION CONTROL SERVICE – HAI REPORTING TEMPLATE SUMMARY

There was a paper submitted [Paper No. 11/21] by the Medical Director covering the Board-wide infection prevention and control activity and the paper on the revised HEAT target for S.aureus Bacterium (SAB).

As agreed at the last meeting, the report was now on an exception reporting basis in order to cut down on the duplication of the full report submitted to the NHS Board meeting. The NHS Board continued to work towards the revised 2013 HEAT target of 0.26 cases of SABs per thousand occupied bed days. The most recent results demonstrated a rate of 0.35. The HEAT targets of 2010 and 2011 had both been achieved; however, more SABs were being identified in patients who were being admitted from home or nursing homes and actions to prevent these were limited and Dr Cowan advised this would make the revised target difficult to achieve. Dr Cowan had been invited by SGHD to highlight the difficulties that the revised 2013 HEAT target may cause.

The Convener asked what actions may be taken in order to deal with community based SABs. It was reported that the Public Health Unit were reviewing nursing homes and also GPs' antibiotic prescribing. The outcome from this work by Public Health would be reported to the Committee in January 2012.

**Medical
Director**

NOTED

27. CLINICAL RISK MANAGEMENT – CORPORATE REPORTING

There was submitted a paper [Paper No. 11/22] by the Medical Director on the current reporting arrangements on clinically related Fatal Accident Inquiries and he also gave a verbal report on significant clinical incidents.

Mr Crawford was keen to ensure that the Quality and Performance Committee had an adequate knowledge of the NHS Board's Clinical Risk Management arrangements and that Corporate Reporting focused on the frequency and form of patient harm associated with care provided by NHS GG&C; priorities for safety improvement and the improvement strategies for making care safer. Mr Crawford set out the model template in relation to formal routine reporting and indicated that added to this list would be the significant Fatal Accident Inquiries and clinical legal claims.

Members supported this template and this would be presented on a Directorate-by-Directorate basis which followed the format of reporting to the Acute Services Division clinical structures and senior management team.

The Convener indicated that it had been raised with him that the new Quality and Performance Committee no longer had the focus on the Acute Services specialty based presentations/scrutiny which the Clinical Governance Committee had. He asked Members if this is something that should be considered further in ensuring transparency of patient safety within Acute Services.

Members welcomed this approach and considered that a report and presentation should be provided to the Committee in a similar manner as the scrutiny of CH(C)Ps was being planned. Dr Cowan suggested that such presentations should be targeted to coincide with the publication of National Reports/major audits of services in order to ensure they were topical and Members would therefore be given an opportunity to see the steps which were being taken within NHS GG&C in relation to findings/recommendations of such reports. This was welcomed and Dr Cowan and Mr Crawford would prepare a programme for the next 12 months which would be built into the forward look of agenda items for future Quality and Performance Committee meetings. It was recognised that this may result in each CH(C)P being scrutinised once every two years rather than annually. The current arrangement with Non-Executives sitting on CH(C)P Committees, Organisational Performance Reviews and other levels of scrutiny were viewed as adequate should CH(C)P reporting move to bi-annual. This would be reviewed by the Committee after a year.

Dr Cowan provided Members with a verbal update on two significant clinical incidents and provided Members with the outcome in both cases.

DECIDED:

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|----|---|-------------------------|
| 1. | That future reports and briefings at Seminars provide Members with a full description of the NHS Board's Clinical Risk Management arrangements. | Medical Director |
| 2. | That the template described in the paper be modelled for future reporting. | “ |
| 3. | That the Medical Director provide a verbal report on significant clinical incidents. | “ |
| 4. | That the Medical Director draw up a programme of National Reports/major audits which would lead to reports being submitted to the Committee. | “ |

28. INFECTION CONTROL – ANNUAL REPORT – 2010/11

There was submitted a paper [Paper No. 11/23] by the Medical Director providing the annual Infection Control Report – 2010/11.

The Annual Report outlined progress within NHSGG&C against its key objectives set out in the 2010/11 Annual Infection Control Programme. It was reported that the NHS Board had implemented the range of measures and controls which had successfully delivered the March 2011 HEAT targets for SABs and Clostridium Difficile infection. During 2010/11 the then Clinical Governance Committee received ongoing assurance through the publication of bi-monthly reports on key infection prevention and control performance indicators. Reports were also sent bi-monthly to the NHS Board.

DECIDED:

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|---|-------------------------|
| That the Annual Infection Control Report – 2010/11 be endorsed. | Medical Director |
|---|-------------------------|

29. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was a paper submitted [Paper No. 11/24] from the Head of Performance and Corporate Reporting setting out the first attempt to bring together high level information from separate reporting strands to create a more integrated view of the NHS Board's performance. The development of the Health Care Quality Strategy for NHS Scotland (May 2010) provided the opportunity for aligning the wide range of measurements across the NHS to assist in driving progress towards the Quality Strategy ambitions. The report was work in progress in both format and content and it did not aim to give a comprehensive level of detailed performance throughout the organisation. Its purpose was to create an overall sense of where the NHS Board was achieving the ambitions set out in the Quality Strategy and to signpost to sources of information/greater detail if required.

The Integrated Quality Performance Report was part of the performance activity within the NHS Board which included Organisational Performance Reviews, Participation Standard, Health Care Environment Inspections, Annual Review and the Performance Management System for Senior Managers.

Members welcomed the integrated report and offered the following comments to improve future reporting:-

- The other papers on the Quality and Performance Committee agenda should be able to be referenced back to the Integrated Quality and Performance Report.
- Presentation of the traffic light approach to be reviewed where Red required action and this was highlighted in the report and Green was acceptable. In addition, it may be possible to cover this approach in columns for ease of presentation to Members.
- The use of Grey should be considered further; not all data-sets lend themselves to two-monthly reporting and this needed to be recognised.
- Consider moving the person-centredness element of the report to the beginning.

**Head of
Performance
& Corporate
Reporting**

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Mr Calderwood thanked Members for their comments and consideration of the report and indicated that the Corporate Management Team would consider the comments made and reflect the outcome of that discussion in the future report to the Committee.

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NOTED

30. CLINICAL GOVERNANCE IMPLEMENTATION GROUP MEETING HELD ON 15 AUGUST 2011

There was submitted a paper [Paper No. 11/25] which set out the Clinical Governance Implementation Group minutes of its meeting held on 15 August 2011.

Mrs Hawkins agreed to bring a paper to the Quality and Performance Committee in March 2012 on the Prison Health Services which would be managed by the NHS Board from 1 November 2011.

**Director of
Glasgow City
CHP**

NOTED

31. QUALITY AND POLICY DEVELOPMENT GROUP MEETINGS HELD ON 22 JUNE 2011 AND 17 AUGUST 2011

There was submitted a paper [Paper No. 11/26(i) and 11/26(ii)] setting out the Quality and Policy Development Group minutes of its meetings held on 22 June 2011 and draft minutes of its meeting held on 17 August 2011.

NOTED

32. PARTICIPATION STANDARD - UPDATE

There was submitted a paper [Paper No. 11/27] from the Nurse Director and Head of Performance and Corporate Reporting setting out the NHS Board's performance against the Participation Standard. This had been the first time that the NHS Board had been assessed by the Scottish Health Council's new process and the paper highlighted the NHS Board's self-assessed level and that as assessed by Scottish Health Council.

The standards in relation to systems and processes in place to meet the statutory requirements in relation to the Participation agenda; the public feeding into governance and decision making arrangements and the culture of participation forming part of the day-to-day planning and delivery of services would be discussed as part of the NHS Board's Annual Review with the Cabinet Secretary for Health, Wellbeing and Cities Strategy on 17 October 2011.

The 90-page self-assessment was available to Members on request and NHS Board officers worked with patient representatives in drawing up the self-assessment which required a vast amount of detail and evidence to support the full submission.

It was the intention to produce guidance to Directors and senior managers on Standards 1 and 2. The same will apply for Standard 3; however, a corporate session will be held to discuss aspects of this Standard in order to agree the best way forward in achieving future compliance.

Each part of the organisation would provide a report to the Quality and Performance Committee in the Spring of 2012 on achieving the Participation Standards.

Members emphasised the need to ensure that the Standards became embedded into the culture of the organisation and the core of what was being delivered. Experience had suggested that recording the evidence as it occurred was the best approach to ensure future Standards were met. As the Involving People Committee responsibilities were now part of the Quality and Performance Committee, this would be an important area of monitoring for the Committee going forward.

NOTED

33. **OVERVIEW FOR CONTRACTING FOR NHS CONTINUING CARE PARTNERSHIP BEDS AND LOCAL AUTHORITY RESIDENTIAL CARE BEDS IN INVERCLYDE**

There was submitted a report [Paper No. 11/29] from the Director of Glasgow City CHP providing an update on the current position on the procurement process for the re-provision of adult and older people's continuing care requirements from Ravenscraig Hospital.

NHSGG&C and Inverclyde Council were currently going through a joint procurement process and tenders were submitted in February 2011 which, unfortunately, the evaluation process highlighted did not fully meet the requirements of both organisations. It had been necessary therefore to return to a new tender process. The Invitation to Tender was amended and issued in August 2011 with tenders due by 23 September 2011. The intention would be to submit a paper to the Quality and Performance Committee and the Policy and Resources Committee of Inverclyde Council in November 2011 hopefully seeking acceptance of a competent tender.

Mrs Hawkins described the three additional options which had arisen since the procurement process commenced in September 2009 and which would be considered in parallel to the evaluation stage of the submitted tenders in September 2011.

Mr Calderwood asked that Mrs Hawkins ensure that Inverclyde Council fully recognised the impact of Option 3 on the 10 adult continuing care beds.

Mr Winter asked about removing the cap on prices as contained within the contract terms and Mrs Hawkins agreed to check this and advise Mr Winter of the outcome. Mr Winter also suggested that the indicative timetable may be ambitious.

**Nurse
Director/
Head of
Performance
& Corporate
Reporting**

“ “

**Director,
Glasgow City
CHP**

“ “

**Director,
Glasgow City
CHP**

Ms Brown enquired about the two registered health care facilities in Inverclyde leased by Southern Cross, in particular in relation to the discussions/negotiations with current landlords to consider the future of these facilities. Mrs Hawkins advised that any option would be a lease option and Inverclyde Council were considering carefully the issues with Southern Cross in relation to the Newark Nursing Home in Port Glasgow and the Merino Court in Greenock.

DECIDED:

1. That the progress of the procurement process for the provision of Partnership beds in Inverclyde be noted.
2. That the inclusion of the three additional options outlined as part of the tender evaluation process in November 2011 covering specification, timeline and financial be approved.
3. That a paper be submitted to the Quality and Performance Committee in November 2011 for approval to contract award.

**Director,
Glasgow CHP**

“ “

34. STAFF GOVERNANCE COMMITTEE MEETING HELD ON 5 JULY 2011

There was submitted a paper [Paper No. 11/30] setting out the Staff Governance Committee minutes of its meeting held on 5 July 2011.

NOTED

35. FINANCIAL MONITORING REPORT TO 31 JULY 2011

There was submitted a paper [Paper No. 11/31] from the Director of Finance setting out the Financial Monitoring Report for the 4-month period to 31 July 2011.

As at 31 July 2011 the NHS Board was reporting expenditure levels running £3.5m ahead of budget and this was mainly attributable to the timing of implementing cost saving plans and some in-year cost pressures pushing expenditure above budget.

Within Acute Services expenditure was running £1.7m over budget with increased expenditure due to the timing of achieving planned cost savings and cost pressures principally relating to non-pay budgets. Expenditure within NHS Partnerships was running £0.9m over budget with the most significant cost pressure within the CH(C)Ps being expenditure on in-patient elderly mental illness. Expenditure within Corporate Services was running £0.9m ahead of budget and this was mainly in relation to interpreting costs and additional legal costs being incurred in handling the Vale of Leven Hospital Public Inquiry.

Mr James reported that it was considered a year-end break-even position remained achievable.

Mr James provided Members with information on the draft figures being reviewed for Month 5 and he would try and ensure, depending on the timing of Committee meetings, that such information was able to be reported to the Committee in future. He also advised that he would submit a half-year review of the NHS Board's finances in December 2011.

**Director of
Finance**

NOTED

36. UPDATE FROM THE MAY/JUNE 2011 ORGANISATIONAL PERFORMANCE REVIEWS

There was submitted a paper [Paper No. 11/32] from the Head of Performance and Corporate Reporting setting out the overview of the key themes and issues which had emerged from the May/June 2011 round of Organisational Performance Reviews. In addition, the individual Organisation Performance Reviews were enclosed for Acute Services and each CH(C)P.

Mrs Gibson reminded Members that the Organisational Performance Review aimed to ensure a focus on how effectively each part of the organisation was delivering its agreed contribution to the achievement of corporate priorities as set out in each of the Planning and Policy Frameworks. It focused on HEAT targets, local key performance indicators and areas of planned activity outlined in the Local Development Plans.

The paper drew out examples of good practice, together with corporate themes/issues which required further consideration across NHSGG&C.

Ms Brown asked about the progress being achieved within Acute Services in relation to dementia. Mrs Grant advised that the Rehabilitation Assessment Directorate was establishing a group to deliver proposals on a comprehensive list of actions to ensure progress on improvements with the dementia services.

The Convener asked about the progress with the process in relation to the Christie Ward at the Vale of Leven Hospital and Mrs Hawkins advised that this issue would be submitted to the NHS Board at its October meeting.

**Director,
Glasgow CHP**

In relation to monitoring the Change Fund, Mr Calderwood advised that a submission was due to be given to the Ministerial Task Force covering the actions and progress of the first six months and this report would also be submitted to the Quality and Performance Committee meeting in November 2011.

**Chief
Executive**

Mr Shanks asked if the feedback from the Organisational Performance Reviews was submitted to each individual CH(C)P Committee and Mrs Hawkins confirmed that this was indeed the case.

NOTED

37. ANNUAL REVIEW UPDATE

There was submitted a paper [Paper No. 11/33] from the Head of Performance and Corporate Reporting providing an update on the arrangements for the NHS Board's Annual Review to be held on 17 October 2011.

The Annual Review would again be Chaired by the Cabinet Secretary for Health, Wellbeing and Cities Strategy and one of the changes this year was that there would be a joint meeting between the Area Partnership Forum and the Area Clinical Forum with the Cabinet Secretary.

Members also received a copy of the Annual Review Assessment – 2011 for information.

NOTED

38. CH(C)P COMMITTEE GOVERNANCE ARRANGEMENTS

There was submitted a report [Paper No. 11/34] from the Head of Performance and Corporate Reporting setting out an annual cycle of reporting to CH(C)P Committees covering core topics which should be reported to Committee.

Following the changes to the NHS Board's governance arrangements and the establishment of the Quality and Performance Committee, Members had raised the importance of ensuring consistency in the way in which CH(C)P Committees fulfilled the financial service, clinical and staff governance responsibilities which they carried as a Subcommittee of the NHS Board.

Members welcomed the requirements for consistency in terms of monitoring key performance areas and it was recognised that the reporting frequency in the paper was a minimum and there would be some Committees which would receive more frequent reports than that recommended in the guidance.

Ms Brown asked if reporting/monitoring could include inequalities. This was agreed and the reporting frequency to the Quality and Performance Committee by each CH(C)P would be affected by the discussions earlier in the agenda on clinical risk management arrangements.

**Head of
Performance
& Corporate
Reporting**

NOTED

39. NEW SOUTH GLASGOW HOSPITALS AND LABORATORY PROJECT: PROGRESS UPDATE – STAGES 1, 2 & 3

There was submitted a paper [Paper No. 11/35] from the Project Director, New South Glasgow Hospitals and Laboratory Project, setting out the progress against each stage of the development of the new Laboratory, design development in the new Hospitals and construction of the new Adult and Children's Hospitals.

Mr Seabourne advised that the Laboratory Project remained on programme for completion on 10 March 2012. The main focus of work was now the internal fit-out on all levels which included installation of the mechanical and engineering services, ceilings, decoration, flooring and fitted furniture. The equipment issues would be separated into those which were to be installed in advance of the Practical Completion and those which would be installed as part of the migration process after hand-over. Group 1 equipment would be supplied and installed by the Contractor as part of the Contract and Group 2, 3 and 31 would be procured or transferred by NHSGG&C.

The Site Facilities Management Team would oversee the commissioning and migration of the services into the Laboratory Medicine and Facilities Management building from hand-over on 10 March 2012.

Learning from the commissioning of the new Ambulatory Care Hospitals, a Staff Handbook would be produced for staff moving into the new Laboratory building with the handbook available electronically and hard copy for those who would not have access to a personal computer. Site visits by staff were under way and had been ongoing throughout August 2011.

In relation to Stage 2 of the New Adult and Children's Hospitals, Mr Seabourne advised on the issues which had emerged from the 1:50 process – namely, increase the size of one of the interventional theatres; conversion of an ENT consulting room to a hearing test room; conversion of a bedroom to a treatment room in ENT; adaptation of the therapy pool (Children's Hospital); installation of a piped sterile water system to the renal departments within the Children's Hospital. The details and the costs of these were currently being assessed.

In relation to Stage 3, the Project remained on programme to be completed by March 2015. The main focus of work was the excavations, earthworks, and the concrete sub-structure and super-structure. The piling works were anticipated to be completed by mid-October 2011. Part of the planning consent required monitoring of the ground conditions and the Contractor advised that ground-water laboratory analysis had been undertaken which indicated PAH contaminants far greater than previously recorded. On site de-watering of deep excavations had been initiated and this may have been affecting ground water conditions on site. Meetings had been held with the Contractor to revise the frequency of monitoring to monthly for ground water during de-watering and 6 months post de-watering, coming to an end (May 2012).

Mr Seabourne advised in terms of community benefits that 115 new entrants had been recruited and of this number, 26 were apprentices. A further 10 apprentices were scheduled to commence in October 2011 and a training and recruitment centre on site was now operational and staffed by Glasgow Regeneration Agency. Supported by Glasgow City Council, the Contractor had a meet-the-buyer session in the City Chambers on 5 September and this was attended by 60 businessmen. The Brookfield Multiplex Healthcare and Life Sciences Suite at Cardonald College was to be formally opened by the Deputy First Minister and Cabinet Secretary for Health, Wellbeing and Cities Strategy on 21 September 2011.

Mr Seabourne highlighted the changes approved and impacting on the Contract target price and Mr Ross took Members through the potential compensation events and movements since the last report in July 2011.

Mr Niall McGrogan, Head of Community Engagement and Transport had provided Members with a travel planning document for the New Southside Glasgow Hospitals and advised that work was under way in terms of planning for the Hospital which was yet to be built and would not be open until 2015. It was recognised that the current site was congested and it was intended to remedy that for the New Southside Hospital and try and ensure that it was at the centre of transport services. Members welcomed the information from Mr McGrogan on the travel planning for the New South Glasgow Hospitals development.

NOTED

40. DATE OF NEXT MEETING

9.00 a.m. on Tuesday, 15 November 2011 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0HX.

The meeting ended at 12.35 p.m.