NOT APPROVED AS A CORRECT RECORD

DRAFT

QPC(M)12/05
Minutes: 83 - 104

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Quality and Performance Committee at 9.00 am on Tuesday, 18 September 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
Ms M Brown
Mr P Daniels OBE
Mr I Fraser
Cllr M Kerr (to Minute 97)
Cllr A Lafferty
Cllr J McIlwee
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 89)
Ms R Crocket
Mr R Finnie
Mr P James
Mr A O Robertson OBE (from Minute 92)
Rev Dr N Shanks

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

Mr A Brown	..	Audit Scotland
Mr J Crombie	..	Director, Surgery and Anaesthetics
Mr T Curran	..	Head of Capital Planning (to Minute 90(b))
Mrs J Grant	..	Chief Operating Officer
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Ms P Mullen	..	Acting Head of Performance and Corporate Reporting
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. 98)
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (for Minute No. 98)
Mrs J Still	..	Head of Administration, Renfrewshire CHP

ACTION BY

83. WELCOME AND APOLOGIES

The Convener welcomed Cllr M Kerr and Cllr A Lafferty to their first meeting of the Committee and welcomed Cllr J McIlwee back on to the Committee. He also welcomed Mr A Brown, Audit Scotland, Mr J Crombie, Director – Surgery & Anaesthetics, Acute Services Division, Mr A Curran, Head of Capital Planning and Mrs J Still, Head of Administration, Renfrewshire CHP to the meeting.

Apologies for absence were intimated on behalf of Ms R Micklem and Mr B Williamson.

84. DECLARATIONS OF INTEREST

Declarations of interest were raised in relation to the following agenda items to be discussed:–

Item 4(c) – Contract for NHS Partnership Beds and Local Authority Residential Care Beds: Inverclyde – Cllr J McIlwee and Mr I Fraser.

Item 14 – Integration of Health & Social Care: Response to Consultation - Cllr J McIlwee.

Item 4(b) – Western Infirmary – Site B: Update – Mr P Daniels and Cllr M Kerr.

85. MINUTES OF PREVIOUS MEETING

On the motion of Mr K Winter and seconded by Mr I Fraser, the Minutes of the Quality and Performance Committee meeting held on 3 July 2012 [QPC(M)12/04] were approved as a correct record.

NOTED

86. SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) - UPDATE

There was submitted a paper [Paper No. 12/71] by the Medical Director providing an update on the Acute Adult Core Programme and on the set up of the new Mental Health programme.

Two nationally set aims had been confirmed for the Adult Acute Core Programme – (i) to ensure that at least 95% of people receiving care do not experience harm; (ii) to reduce the Hospital Standardised Mortality Ratio (HSMR) by 20% by 2015.

The Board's HSMR analysis for the quarter January to March 2012 was lower than the national level and the overall reduction within the NHS Board was greater than the overall reduction at national level. The initial aim was to achieve a 15% reduction in HSMR by the end of 2012.

The challenge for the Acute Services Division was spreading the models of reliable care processes from the initial pilot locations to all relevant patient areas and good progress continued to be positively reviewed by the national team. Sustained reliability had been achieved in 85% of the critical care programme in intensive care units and good progress was being achieved in High Dependency Units. Dr Armstrong highlighted the critical care workstreams within the Intensive Care Units and advised members that the programme was popular with staff as they saw specific improvements being achieved across the units and for the benefit of patients.

In response to the question from the Convener, Dr Armstrong advised that medicines reconciliation was targeted at the areas where significant improvements could be made. Currently the target was emergency care and medical services and this would be followed by surgical receiving. Currently the programme was approximately half way through the targeted circa 40 wards within the NHS Board's area.

NOTED

87. INFECTION CONTROL SERVICE – HAI REPORTING TEMPLATE – AUGUST 2012

There was submitted a paper [Paper No. 12/72] 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 the full report was submitted to each NHS Board meeting and this report covered the quarter January to March 2012.

The most recently validated results available demonstrated a Staphylococcus Aureus Bacteraemias (SAB) rate of 0.275 per 1,000 average occupied bed days (AOBD) against a 2013 HEAT target of 0.26 cases. With more infections being identified when patients were admitted from the community, the actions to prevent these were limited and would make the 2013 target difficult to achieve. This was the reason that the Board had started a process to examine the epidemiology of these cases to determine how best to intervene.

The NHS Board's rate for Clostridium Difficile infection for the quarter – January to March 2012 was 0.25 per 1,000 total occupied beds days for those patients aged 65 and over, against the 2013 HEAT target of 0.39.

The NHS Board's compliance with hand hygiene was 95% for the period 21 May to 1 June 2012 against a Scottish average of 96%.

In relation to surgical site infection surveillance, apart from the reduction of long bone fracture, the other measures were below the national average.

The report provided an update on the increase in surgical site infection in caesarean section wounds in the Royal Alexandra Hospital which had been investigated and now returned to normal and also the highly unusual strain of infection identified at the Renal Unit, Western Infirmary where no further cases had been detected.

Dr Armstrong advised members of the action taken in relation to an incidence of inappropriate prescribing of particular antibiotics, progress being made in two Acute directorates to further reduce SAB rates and future reporting on deaths associated with any Norovirus outbreak would be consistent with national reporting guidelines, ie only those patients who during outbreaks have the causative organism listed as either an underlying or contributory cause of death.

NOTED

88. CLINICAL RISK MANAGEMENT REPORT; SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS

There was submitted a paper [Paper No. 12/73] by the Medical Director on Adverse Clinical Incidents. The reporting of the adverse clinical incidents had been displayed in two separate charts in order to highlight the position within Acute Services and separately within Partnerships.

The report set out the definition and process followed in relation to Significant Clinical Incidents; within Acute Services clinical incidents were routinely reviewed at each meeting of the Clinical Governance Forum. For Partnerships the majority of

cases were related to mental health and these were reported in to the Mental Health Clinical Governance Group.

Dr Armstrong advised members that a Freedom of Information request had been received from the media seeking information on the process for handling Significant Clinical Incidents and also requested copies of the redacted investigation report into the individual Significant Clinical Incidents within the NHS Board over the last year. All NHS Boards in Scotland had received a similar request and the NHS GG&C responded by providing a note on the process and redacted copies of the 43 cases which had been completed in the last 12 months. The information not disclosed from the reports related to personal health information which was exempt from disclosure under the Freedom of Information legislation and the outcome and lessons learned from each case was disclosed in each report. Ms Brown emphasised the importance of the NHS Board providing assurance to the public on the policies and procedures in place to learn lessons from unintended or unexpected clinical incidents which may have led to harm to patients. Dr Armstrong recognised the tensions between maintaining clinical staff's involvement in self-reporting errors in order that lessons could be learned for future care and the requirements of being open and transparent and providing reassurance to the public of the processes in place within the NHS Board. This was recognised in the spirit with which the NHS Board responded to the recent Freedom of Information request. However it was important to ensure that staff did have protected time and space to share experiences in a way that encouraged them to engage with this process for the greater benefit of patients accessing such services in the future.

Dr Armstrong advised that a review was being undertaken as a result of Health Improvement Scotland publishing a critical review of the management of Significant Adverse Events. This followed the publicity attached to the critical decision notice from the Scottish Information Commissioner into Ayrshire & Arran's response to a Freedom of Information request in relation to its processes and procedures in relation to Significant Clinical Incidents. Dr Armstrong would provide an update on the progress being made by this review to the Committee in November and would give consideration to future reporting to the Quality & Performance Committee on the handling and lessons learned from Significant Clinical Incidents, recognising the need to ensure sustainable changes in processes and procedures. Mr Sime referred to the arrangements held within the former Clinical Governance Committee meeting and again asked if the Medical Director could provide a verbal update at each meeting of the Committee on current and ongoing cases. However, there were over 100 cases per annum and there is a need to consider how best to do this. It was agreed that the reporting of SCI at a corporate level should be considered by the ongoing review. This was agreed.

Dr Armstrong provided Members with a detailed summary of a particular case which had been withheld in relation to the Freedom of Information request mentioned above and also provided a detailed summary of the ongoing and forthcoming Fatal Accident Inquiries.

DECIDED:

1. That the surveillance of adverse clinical incident report be noted.
2. That the Medical Director provide an update to the next meeting of the Committee in relation to the review being undertaken of the procedures related to the handling and reporting of Significant Clinical Incidents. **Medical Director**

89. MINUTES OF THE CLINICAL GOVERNANCE IMPLEMENTATION GROUP MEETING – 13 AUGUST 2012

There was submitted a paper [Paper No. 12/82] in relation to the Clinical Governance Implementation Group meeting. Minutes of its meeting held on 13 August 2012 together with a summary of the key items were discussed at this meeting. Dr Armstrong took Members through the summary report.

NOTED

90. MATTERS ARISING

(a) Rolling Action List

Noted.

Mr P Daniels and Councillor M Kerr left the meeting.

(b) Proposed Disposal of Site B and Production Pharmacy Building – Western Infirmary

In relation to Minute No.46(b) – Western Infirmary – Site B; Update – there was submitted a paper by the Chief Executive [Paper No. 12/68] updating Members on the proposed disposal of the balance of the Western Infirmary site including the Production Pharmacy Unit on University Place and seeking approval to the provisional agreed sale and short-term leased-back terms. Mr T Curran, Head of Capital Planning attended to take Members through the paper and described the background, disposal options and proposed sale terms.

On completion of the Acute Services Review, the services from the Western Infirmary would transfer to the new New South Side Hospital from mid-2015 onwards and this would lead to the subsequent closure of the Western Infirmary. Two sites at the Western Infirmary had been identified as part of a legal right of redemption in favour of the University of Glasgow and were sold to the University early this year on the basis of agreed price and terms and conditions relating to the use and timescale of the transfer of the site.

The Quality & Performance Committee had agreed in January 2012 that negotiations with the University be entered into in relation to an off-market disposal of Site B of the Western site. Site B represented the balance of the Western Infirmary site extending to circa 3.7 acres predominantly fronting Church Street but with some frontage to Dumbarton Road. The University requested inclusion of the Production Pharmacy Building on University Place in the sale and it was considered that there was a case to be made for its inclusion.

Site B was subject to an unfavourable planning designation and it wrapped around a small but prominent site at the corner of Church Street/Dumbarton Road which was in the University's ownership. In agreeing an appropriate price for an off-market sale, the NHS Property Transaction Handbook stated that the NHS Board must ensure that it was clear beyond doubt that the price achieved was greater than would have been achieved in open tender. Mr Curran explained in detail the disposal options and the proposed sale terms together with the claw-back arrangements which ensured the NHS was able to

share in any profit arising from land sales or development for any non-"tertiary education" use which may be achieved by the University at a later date.

Members were content with the arrangements set out in the paper and the Director of Finance indicated that he was in discussions with the Scottish Government Health Directorate about the prospects of retaining the full market sum achieved in this sale.

DECIDED:

That the Chief Executive be instructed to progress the sale of Site B and the Production Pharmacy as described within the paper and within a target timescale of the end of November 2012. **Chief Executive**

Mr P Daniels and Cllr M Kerr returned to the meeting.

(c) Update – NHS Partnership Beds and Local Authority Residential Care Beds in Inverclyde

In relation to Minute No. 66(b) – Proposal to Award Contract for NHS Partnership Beds and Local Authority Residential Beds in Inverclyde – there was submitted a paper from the Director of Glasgow City CHP [Paper No. 12/69] updating Members on the current position on the commissioning of specialist nursing care for older people with dementia and adult mental health intensive supported living services in Inverclyde.

These services were a crucial element of a joint process undertaken in partnership with the Council as the final step in the current programme of the closure of Ravenscraig Hospital and were part of an initiative to modernise mental health services in Inverclyde. This was the fifth report to the Quality & Performance Committee and following the decision at the last meeting to award the contract to Quarriers, unfortunately the joint procurement process came to an end on 13 July following Quarriers withdrawal from the process.

Following a review of the arrangements it was now proposed that the NHS Board and Inverclyde Council separately commission the elements of the service to meet their own individual requirements. This decision was informed by the two unsuccessful attempts to jointly procure from the market place and the fact that new opportunities now existed that provided alternative options for both the Board and the Council that allowed greater choice, flexibility and was more cost effective.

The NHS Board now intended to procure 42 NHS mental health continuing care beds (30 for older persons and 12 for adults). Following a review of the need for specialist dementia services, Inverclyde Council now intended to commission 12 older adult dementia places rather than the original 24 places.

The paper set out the commissioning options and proposed timetable to meet the Ravenscraig Hospital closure timetable of July 2014.

Councillor McIlwee intimated his disappointment at this outcome. He had taken the opportunity of meeting the families of patients at Ravenscraig Hospital and it was their expressed wishes that all efforts should be made to ensure there are no further delays or extensions to the proposed timescale for the re-provision of these services. Mr Finnie enquired about the rationale which saw the preferred bidder withdraw and this leading to a withdrawal from

the joint procurement process and both the NHS Board and Council now commissioning separately the services required. Mrs Hawkins advised that Inverclyde CHCP continued to ensure close working between both parties but the reviews undertaken had led to a financial and more cost effective plan and one which was hopefully deliverable against the tight timetable. Councillor McIlwee emphasised that the Board and Inverclyde Council continued to work closely in all areas relating to health and social care.

Ms Brown understood the position of each but wanted reassurance on the mix of the NHS beds covering 30 for older people and 12 for adults. She also enquired about the reduction in the older adult dementia places and whether these included dementia and chronic functional mental illnesses. Mrs Hawkins advised that it was important to provide services close to the local community within Inverclyde rather than splitting these services and causing patients and relatives to travel to other locations within NHS GG&C. Whilst close working with the Council did continue, particularly around the development of services that attracted resource transfer, it was the Council who would govern which services it required to commission from its assessment of the needs of its population.

It was felt that it would be useful to have a NHS Board Seminar covering the mental health strategy and related matters. **Director of Glasgow CHP**

DECIDED:

1. That, the conclusion of the original procurement process, be noted.

2. That, the proposal that NHS GG&C and Inverclyde Council separately commission the elements of service to meet their individual requirements, be noted.

3. That, the options being worked up for comparison purposes, be endorsed. **Director of Glasgow CHP**

4. That, a report be submitted to the November Quality & Performance Committee on the business case drawn up for the preferred option and update on progress. **Director of Glasgow CHP**

(d) Gastric Feeding Protocols in Nursing Homes - Feedback

In relation to Minute 71 – Clinical Risk Management Report – Surveillance of Adverse Clinical Incidents - Ms Crocket advised that the responsibility for having gastric and feeding protocols in place lay with the individual nursing homes and in terms of meeting professional standards, the nurses themselves. The 2008 Knowledge Skills Framework did not cover this as a core requirement. It was recognised that it was as an infrequent occurrence within nursing homes and therefore viewed as an additional requirement.

NOTED

91. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No.12/70] from the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHS Greater

Glasgow and Clyde's performance in context of the Quality Strategy.

Of the 41 measures which had been assigned a performance status based on their variance from trajectories and/or targets outlines, 28 were assessed as green; 9 as amber (performance within 10% of trajectory) and 4 as red (performance 10% outwith meeting the trajectory). The areas where improvement was required (and an exception report provided) were:-

1. Faster access to specialist services – Child and Adolescent Mental Health (CAMHS)
2. Acute bed days lost to delayed discharge
3. New outpatients – maximum 12 weeks from referral
4. Sickness absence

In addition the findings of the 2012 inpatient experience survey were now available and a performance update against those measures previously reported was provided within the patient focus quality dimension of the main report.

Rev. Dr. Shanks expressed his appreciation of the clarity of the report however did not think it was acceptable that four CAMHS teams were currently breaching the 31 week trajectory as at July 2012. The report highlighted that the current maximum wait for access to specialist services was 50 weeks. Mr Fraser expressed his severe concerns at the failure to meet the trajectory of meeting the 26 week target by 31 March 2013. He believed management needed to be creative and deploy additional resources to ensure better performance in this important area of the NHS Board's work. Ms Renfrew intimated that there was a detailed programme available bringing about improvements to achieving faster access to these specialist services. It was taking longer than had been hoped but the report did indicate the expectations of improvement during September/October when vacancies had been filled and workforce models for the CAMHS framework had been implemented. It was agreed that the future report should provide details of the number of patients within the different waiting time brackets in order that Members had a better understanding of the distribution of patients across the waiting times. It was also agreed that the intended NHS Board Seminar on the mental health service should include elderly mental health care and also the focus on the CAMHS service.

Director of Glasgow CHP

Mr Winter asked why the number of patients waiting over the 12 weeks for referral to outpatients was shown and not the percentage and also the reasons for the high number of patients on the unavailable outpatient and inpatient and day case waiting lists. Mrs Grant advised that a major review of waiting list processes was underway in the Institute of Neurosciences to update service models for outpatient pathways in addition to the work underway in relation to inpatient/day case pathways. She had shown the number of outpatients waiting longer than 12 weeks, which were all from the Institute of Neurosciences, as it was a small number and thought it important to highlight this to Board Members. The 2,689 unavailable patients on outpatient waiting lists and 3,957 unavailable patients on inpatient and day case waiting lists were covered by social and medical reasons. Sometimes dates of admission didn't suit patients due to holidays or other social reasons and other patients may have had other medical complications which required to be resolved before proceeding with any treatment. The draft Access Policy would be submitted to the NHS Board in October 2012 to agree the principles around meeting the waiting time targets and also what constituted a reasonable offer of an appointment within NHS GG&C. The intention would be that a reasonable offer of an appointment would be an appointment within a hospital within the NHS GG&C area.

Ms Brown asked if a seminar or away day could incorporate the development and

setting of key performance indicators. This was agreed as a future Seminar topic. She was also keen to receive more information on the Change Fund in relation to the benefits accrued from this additional funding.

Ms Mullen agreed that future reporting on bed days lost/delayed discharges would also have a table excluding adults with incapacity. CH(C)P Committees received updates on the use of Change Funds within their own areas and it was reported that Inverclyde was now hitting the monthly targets set for bed days lost to delayed discharges. Unfortunately Glasgow City and Renfrewshire Council continued to be significantly adrift from the set target.

Dr Benton reflected that some nursing homes were indeed over-subscribed and while beds were available in other nursing homes, patients and the relatives of patients did not always find these homes suitable.

NOTED

92. HEALTHCARE IMPROVEMENT SCOTLAND – UNANNOUNCED INSPECTION VISIT – CARE OF OLDER PEOPLE IN ACUTE HOSPITALS – ROYAL INFIRMARY

Ms R Crocket provided an update on the Healthcare Improvement Scotland's unannounced visit to the Royal Infirmary in July 2012. The first announced visit had taken place in May 2012 and there was a 90% patient and relatives satisfaction level however 17 areas of improvement had been identified. An action plan had been prepared with most actions identified to be resolved by the end of September 2012. The unannounced visit in July had identified two further improvements which would be required:-

1. Assisting patients to the toilet
2. Skin/pressure sores assessed and recorded within six hours of the patient's admission to the ward.

The expanded action plan was being monitored via the Clinical Governance Group within Acute Services and most actions would be completed by the end of September 2012. Ms Crocket agreed to provide a composite report to the Quality & Performance Committee in March 2013 on the announced and unannounced visits by Healthcare Improvement Scotland.

Nurse Director

Dr Benton had worried about the impact on the staff at the Western Infirmary following the publicity following Healthcare Improvement Scotland's visit there earlier this year and this she felt had been unfortunate in terms of staff morale. Ms Crocket indicated that the intention was to identify learning opportunities and areas for improvement which staff could bring about improvements for patients and not dwell on any negative publicity which such reports could attract. It was important to identify the material issues and work with staff on them.

NOTED

93. MANAGEMENT OF SICKNESS ABSENCE WITHIN NHS GG&C

There was submitted a paper [Paper No. 12/74] from the Director of Human Resources providing Members with the measures currently in place to manage sickness absence within NHS GG&C.

The paper highlighted that sickness absence impacted on the ability of the NHS Board to deliver patient care due to the loss of qualified and experienced staff in providing such care directly or indirectly. It also impacted on staff who remained at work and the sickness absence rates for the past two years were set out in an appendix to the report. Current levels within NHS GG&C was 4.47% (against a target of 4%).

Absence monitoring was a regular part of both individual management objectives and as part of the system-wide organisational performance review process led by the Chief Executive. The Workforce Information Team provided regular reports breaking down absence rates specifically to all Acute Directorates, Partnerships and Corporate functions. Detailed reports on absence were also provided to specific departments.

In relation to the policy framework, the NHS Board had in place an Attendance at Work Policy; Dignity at Work Policy and a suite of Work/Life Balance Policies. In addition the NHS Board also has a Staff Health Strategy aimed at improving the health of the workforce, and the themes concentrated on smoking, alcohol, obesity and physical activity and mental health. The NHS Board was also committed as part of this work associated with the national Healthy Working Lives programme and plans were in place to achieve the gold award status across the organisation during 2012/13. Lastly, the Board had its own Occupational Health Service which supported managers in the management of individual employees and supported staff who become ill. There is also an independent Employee Counselling Service which provided confidential support to employees experiencing difficulties.

Sickness could be categorised into two categories, namely short-term absences which accounted for 2% of absences and long-term absences which accounted for 2.5%. The breakdown of the underlying reasons for absence which have resulted in a referral to occupational health highlighted that anxiety, stress, depression and other psychiatric illnesses accounted for approximately 50% of these referred cases. Other musco-skeletal problems (excluding back problems but including neck problems) and back problems accounted for the next highest level of referrals.

Members thanked Mr Reid for a very full report although concern was expressed at the high level of anxiety/stress issues being recorded and whether there was any disconnect between top management and frontline staff. Mr Reid advised that a stress management action plan from a health and safety perspective was in place and this included a stress risk assessment. Detailed reporting by departments was possible as well as across professional groups although it was recognised that not all stress was work related but still had an impact on staff absences.

In relation to relaxation techniques and mindful sessions, these had been highlighted in staff surveys and formed part of elements of the Healthy Working Lives work.

Comparators with the private sector sickness absence rates was not always relevant and Mr Reid advised that in relation to the 4% sickness absence target set for NHS Boards no other territorial Board within NHS Scotland was achieving this target.

Further more detailed reporting will be submitted to the Staff Governance Committee and Mr Reid will bring a paper on violence and aggression to the next meeting of the Quality & Performance Committee in November 2012.

Director of Human Resources

NOTED

94. SCOTTISH PUBLIC SERVICES OMBUDSMAN – REPORT ON IMPLEMENTING RECOMMENDATIONS

There was submitted a paper [Paper No. 12/75] from the Head of Clinical Governance asking the Committee to note investigations concluded by the Ombudsman and to review and comment on the actions taken by the relevant Directorate/Partnership. It was the Committee's function to ensure that the recommendations made by the Scottish Public Services Ombudsman (SPSO) including those recommendations relating to GPs and Dentists were implemented in the interest of delivering safe and effective care.

In relation to the two cases which were ongoing from the last report, it was confirmed that the case in relation to the Acute Services Division and the case in relation to the Dental Practice had both now been concluded and reports had been provided to the SPSO on the improvements made and implementation of the recommendations.

This report covered the three SPSO reports issues in the period April – June 2012 together with the 16 Decision Letters (8 of which related to Acute Services, one to a CHP, 4 to GP practices and 3 to dental practices). The report covered those Decision Letters where an element of the complaint had been upheld and where the Ombudsman had made a recommendation; the remaining 8 Decision Letters had no elements upheld or recommendations from the SPSO.

The three full Ombudsman reports covering two cases within Acute Services and one in Mental Health Services were summarised and the actions taken were highlighted in relation to the recommendations made by SPSO.

Members had a concern about the number of upheld elements of complaints, recognising that SPSO review those cases where the local complaints procedure has been exhausted.

Mrs Grant and Mrs Hawkins explained that SPSO do not take all cases forward for investigation and complex and difficult complaints can cover a number of issues, not all of which are upheld following an investigation/review by SPSO. SPSO are not required to meet the 20 working day target to complete complaints and also use independent advisers to review in detail each individual case and its outcome. Acute Services and Partnerships carry out detailed reviews including Medical and Nurse Directors' involvement to understand what areas have either been missed or not covered by previous Boards' response under the local resolution element of handling complaints. There were occasions where the Ombudsman had introduced a different perspective to an issue rather than identifying a fundamentally different outcome from that of the NHS Board. All efforts will continue to review and learn the lessons from the Reports and Decision Letters of the SPSO in an effort to ensure improvements to the provision of local health services.

NOTED

95. REVIEW OF FALLS – HOSPITAL GOVERNANCE REPORT

There was submitted a paper [Paper No. 12/76] from the Nurse Director which provided information on the Acute Service Division hospital falls governance report.

At the January 2012 of the Committee a request had been made that a report be

prepared on patient falls within the NHS Board in order to highlight the actions taken in relation to falls. The Acute Services Division agreed a Falls Policy in December 2006 and also the establishment of an Acute Services Division Falls Governance Group. Patient falls were reported via the Risk Management Datix System and in 2011 there were 11,481 falls across the Acute Services Division. The paper highlighted the injuries relating to falls and reported that five cases were reviewed as Significant Clinical Incidents. A team of Hospital Falls Co-ordinators were in place and their role was to support the implementation of the Falls Policy in all inpatient areas. In addition there was also a requirement to complete a Falls Risk Assessment within 24 hours of a patient's admission to hospital and a care plan developed to prevent falls where appropriate. It was recognised however that the development of alternative strategies for preventing falls for patients with cognitive impairment could be an area in which further benefit could be brought in terms of falls and harm reduction. This was a priority for the coming year and was jointly being addressed by the Falls Team and the Acute Dementia Advisory Group.

Members welcomed the report and the detailed actions underway and Mrs Spencer asked if a further report could be provided in March 2013 which highlighted the falls across NHS GG&C and not within the Acute Services Division. This was agreed. **Nurse Director**

NOTED

96. PATIENTS' RIGHTS (SCOTLAND) ACT

There was submitted a paper [Paper No. 12/77] from the Director of Corporate Planning and Policy outlining the action required to ensure the NHS Board met the requirements of the Patients' Rights Act and related Charter of Patients' Rights and Responsibilities.

The Patients' Rights (Scotland) Act 2011 was passed by Parliament on 24 February 2011 and gained Royal Assent on 31 March 2011. The aim was to improve patients' experience of using health services and to support people to become more involved in their health and healthcare. The Act placed a duty on Scottish Ministers to publish a Charter of Patients' Rights and Responsibilities and this document will bring together in one place a summary of the rights and responsibilities that patients have in using NHS services. The Charter will be launched from 1 October 2012.

The Act had four key provisions, namely –

1. Taking account of the patient's individual needs and circumstances
2. 12 week treatment time guarantee
3. Right to give feedback or comments or raise concerns or complaints
4. The establishment of a Patient Advice and Support Service

The Charter of Patients' Rights and Responsibilities would cover access to health services, confidentiality covering personal health information, communication and participation, respect and dignity, safety - and the right to raise comments and complaints.

From 1 October 2012 the NHS Board will be required to ensure that eligible patients who are due to receive planned treatment provided on an inpatient or day care basis can expect to start to receive the treatment within 12 weeks from the date they agree to the treatment. The treatment time guarantee did not apply however to the following services –

1. Assisted reproduction
2. Obstetric services
3. Organ and tissue transplantation
4. Designated national services for surgical intervention in spinal scoliosis
5. Treatment of injuries, deformities or disease of the spine by infection or surgical intervention

There will be a need to have a clear access policy covering treatment offers and information for patients and this will be considered by the NHS Board at its October 2012 meeting.

Chief Operating Officer

Mr Crombie described the steps being taken by the Acute Services Division to meet the 12 week guarantee and described the administrative processes being put in place to ensure that this guarantee was met and auditable. The upgrading of existing systems together with manual entry would be undertaken initially to ensure patients were tracked. The nationally agreed Trak-Care system would be implemented across NHS GG&C during the course of 2013.

NOTED

97. HEALTH AND SOCIAL CARE INTEGRATION – RESPONSE TO CONSULTATION

There was submitted a paper [Paper No. 12/78] from the Director of Corporate Planning and Policy setting out the NHS Board's response to the Scottish Government consultation on the Integration of Health and Social Care.

NHS GG&C currently has three fully integrated partnerships within East Renfrewshire, Inverclyde and West Dunbartonshire Councils. These partnerships manage all community health and social care services, including criminal justice and children and family social work. The Partnerships are led by a single Director, jointly appointed by the Councils and NHS Board and are accountable to the respective Chief Executives of both organisations. The Partnership Committees are chaired by a local Councillor and it was the NHS Board's view that these existing Partnerships have demonstrably improved services, reduced duplication for patients, reduced management costs and benefitted from the direct engagement of Councillors in decision making about local health services. The NHS Board response to the consultation should reflect these experiences and also on the creation of the integrated partnership with Glasgow City Council which was then subsequently dissolved due to issues about governance and accountability. The response should therefore also reflect the experience of what did not work.

Members had welcomed the discussion at the September NHS Board Seminar and the overall impression was the draft response captured the range of views discussed at the Seminar.

Members provided detailed comments in relation to paragraphs 2.4, 2.9, 2.10 and 2.11. In addition, Mr Sime was concerned that the NHS Board within its response was not championing enough the workforce section the staff governance standard set for NHS staff and the joint partnership arrangements between management and staff. In addition, the loss of the Staff Governance Forum having a voting member on the Partnership Committee was a concern to Mr Sime. The first point was noted and the response did show regret at the loss of current voting members on Partnership Committees but did acknowledge the different governance and accountability

arrangements from the current CH(C)P Committees. It was the case that those stakeholders remained engaged, strong and influential in the ways of working in decision making of Partnerships in future.

DECIDED:

That, subject to revision as discussed the NHS Board's response for submission to SGHD in response to the consultation exercise undertaken into health and social care integration, be approved. **Director of Corporate Planning & Policy**

98. NEW SOUTH SIDE HOSPITALS – PROGRESS UPDATE – STAGES 2 AND 3 AND CARPARK 1

There was submitted a paper [Paper No. 12/81] from the Project Director of the Glasgow Hospitals and Laboratory Project setting out the progress against Stage 2 (design development of the new hospitals) and Stage 3 (construction of the adult and children's hospitals). In addition, the paper sought Members' approval to the Full Business Case for the development of Carpark 1 on the New South Side Glasgow Hospitals site.

To assist Members Mr Seabourne, Project Director, South Glasgow Hospitals Project, gave a presentation of photographs from the site of the new hospital and explained the progress being made in each area. Members found this visual presentation very helpful in understanding the progress being made in developing the new Adult and Children's Hospitals.

Mr Seabourne made reference to the discussions ongoing between the University of Glasgow and NHS GG&C in connection with the intention to develop a proposal to build a joint teaching and learning facility adjacent to the new Adult and Children's Hospitals. SGHD had been involved in the discussions and the Capital Investment Group of SGHD agreed at their meeting on 28 August 2011 that an Outline and then Full Business Case should be developed for the joint teaching and learning facility. It was hoped to bring the Outline Business Case to the Quality & Performance Committee in January 2013 and current plans were that the NHS would contribute 45% of the funding, the remaining 55% coming from the University of Glasgow. **Project Director**

In response to comments from Members, Mr Seabourne confirmed that there was no ground movement or sinking in relation to the concrete cores that had been constructed and the development was progressing exactly as planned and within budget and timescale. In response to a question from Ken Winter on some of the design issues he was facing, Mr Seabourne explained for example that the water pipes supplying heating etc would need to be tested with air at first instead of water to ensure that the pipes didn't corrode from the inside when sitting for some three years before the hospitals were occupied which was an issue in other hospitals.

In relation to the procurement/transfer of the large pieces of imaging equipment, this process was well underway and a submission would be made to the Chief Operating Officer – Acute Services in relation to the overall plan for major pieces of equipment and which pieces of existing equipment would transfer to the new hospital and when.

Mr Ross covered the change of control process, potential compensation events and overall budget. An investigation was underway in relation to a weather event covering June/July in relation to extraordinary heavy rainfall during that time and impact on the contract.

Carpark 1 – Full Business Case

The Full Business Case for Carpark 1 at the new South Glasgow Hospitals project was considered by Members. Carpark 1 was embedded in the Brookfield Multiplex construction site and close to the entrance of the hospitals. It had originally been thought that the carpark would be outside the construction site, however the winning bid from Brookfield Multiplex had seen this carpark embedded within the construction site.

The Quality and Performance Committee had considered the procurement option at a previous meeting and had agreed a negotiated variation to the current construction contract with Brookfield Multiplex as the most advantageous method for the Board, recognising the increased risks to the main project during the construction phase and possible disruption to the main programme. The capital cost had been identified through negotiation as £11.43 million excluding VAT and fees. The costs had been benchmarked and was deemed by Board Officers and cost advisers to represent value for money. The capital costs would be funded from the existing new South Side Hospital project budget and the revenue costs had originally been recognised in calculating the net savings to be generated from the overall development.

Mr Seabourne confirmed that planning permission had been granted recently to construct the carpark and Members supported the proposal.

DECIDED:

1. That, the progress report and presentation on the development of the design and construction of the new Adult and Children's Hospitals, be noted. — **Project Director**
2. That, the Full Business Case for the carpark 1 at the new South Side Hospitals project for submission to the Capital Investment Group of the Scottish Government, be approved. — **Project Director**

99. FINANCIAL MONITORING REPORT – TO 31 JULY 2012

There was submitted a paper [Paper No. 12/79] providing the financial report for the four month period to 31 July 2012.

The report showed an expenditure outcome of £1million in excess of budget for the first four months of the year, however it was considered that a year end break even position remained achievable.

NOTED

100. UPDATE FROM THE MAY 2012 ORGANISATIONAL PERFORMANCE REVIEWS

There was submitted a paper [Paper No. 12/80] from the Director of Corporate Planning and Policy setting out the updates from the May 2012 Organisational Performance Reviews (OPRs) for the Acute Services Division and each Partnership. This provided the Committee with an overview of some of the key achievements and issues which had emerged from the May 2012 OPRs.

Organisational Performance Reviews were carried out twice a year and focused 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. They focused on HEAT targets, local key performance indicators and areas of planned activity outlined in Local Development Plans.

NOTED

101. LOCAL DELIVERY PLAN – 2012/13

The Director of Corporate Planning and Policy advised that SGHD had approved the NHS Board's Local Development Plan – 2012/13.

NOTED

102. LEVERNDALE HOSPITAL – CAPITAL CONTRACT – DELEGATED LIMITS

The Director of Finance advised that a contract for two 24 bed wards at Leverndale Hospital to replace beds from the Southern General Hospital site has led to the issuing of a contract of £7 million. This sum had been contained within the Capital Plan however with SGHD issuing revised delegated sums to Boards the contract sum was now above the new delegated sum and Mr James wanted to notify the Quality & Performance Committee of this anomaly. The original sum had been within the NHS Board's delegated limit when the process had commenced however, having been required to sign the contract, Mr James was aware that it was no longer within delegated limits. Members noted the position.

NOTED

103. MINUTES OF THE STAFF GOVERNANCE COMMITTEE MEETING – 21 AUGUST 2012

There was submitted a paper [Paper No. 12/83] setting out the Staff Governance Committee minutes of its meeting held on 21 August 2012.

NOTED

104. DATE OF NEXT MEETING

9.00am on Tuesday 20 November 2012 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 OXH

The meeting ended at 12.50pm