DRAFT

QPC(M)13/03
Minutes: 40 - 64

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 21 May 2013 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)

Ms M Brown
Mr I Fraser (To Minute 49)
Cllr A Lafferty
Ms R Micklem
Cllr J McIlwee
Mr D Sime
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
Mr R Calderwood
Ms R Crocket
Dr de Caestecker (Minutes 50-55)
Mr R Finnie
Mr P James

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

Ms J Gibson	..	Head of Performance and Corporate Reporting (To Minute 45)
Mr A Daly	..	Head of Financial Planning & Allocations (To Minute 49)
Mrs J Grant	..	Chief Operating Officer
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP (To Minute 55)
Mr A McIntyre	..	Director, Facilities (Minutes 49-62)
Mr A McLaws	..	Director, Corporate Communications
Ms C Renfrew	..	Director of Corporate Planning & Policy (To Minute 55)
Mr D Ross	..	Director, Currie & Brown UK Limited (To Minute 61)
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (To Minute 61)

40. APOLOGIES

Apologies for absence were intimated on behalf of Dr C Benton BEM, Mr P Daniels OBE, Cllr M Kerr, Mrs P Spencer and Mr B Williamson.

41. DECLARATIONS OF INTEREST

No declarations of interest were raised in relation to the agenda items to be discussed.

42. MINUTES OF PREVIOUS MEETING

On the motion of Mr D Sime and seconded by Ms R Micklem the Minutes of the Quality and Performance Committee Meeting held on 19 March 2013 [QPC(M)13/02] were approved as a correct record, subject to the following amendment:
Minute 26: "New South Glasgow Hospitals – Update" – delete "Strathclyde" and insert "stratified".

43. MATTERS ARISING

(a) Rolling Action List

(i) Outline Business Case: Teaching & Learning Facility
The Scottish Government Capital Investment Group had approved the Outline Business Case. No further action required on the psychological services.

NOTED

(b) Inverclyde NHS Partnership Beds and Local Authority Residential Beds – Up-date
In relation to Minute 24(c) – Inverclyde Partnership Beds – Mrs Hawkins advised that the SGHD Capital Investment Group had approved the submission to procure NHS Mental Health Continuing Care beds at the Inverclyde Royal Hospital site. Bridging Finance arrangements were still being considered. The design work was scheduled to be completed by the end of the month.

Inverclyde Council were working towards awarding a contract for its beds by December 2013. A further report would be submitted to the Committee in September 2013. **Director, Glasgow City CHP**

NOTED

44. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No. 13/32] from the Head of Performance and Corporate Reporting setting out the integrated overview of NHS Greater Glasgow and Clyde's performance. Of the 42 measures which had been assigned a performance status based on their variance from trajectory and/or targets, 25 were assessed as green; 10 as amber (performance within 10% of trajectory) and seven as red (performance 10% outwith meeting trajectory). The areas of key performance change since the last report included:-

- Suspicion of cancer referrals (62 days) – had moved from amber to green;
- Faster access to specialist services – had moved from amber to green;
- Admission to stroke unit – had moved from red to amber;
- A&E Waits to be a maximum of 4 hours – had moved from red to amber;
- Mental Health Services: Nursing Standards Compliance – Food, Fluid and Nutrition – had moved from amber to green;
- Child Fluoride Varnishing applications – had moved from green to red.

Mr Sime asked about the new National Reporting Requirements for child fluoride varnishing applications. Ms Gibson explained that this was the first occasion in

which this performance had been rated red and this had followed the national requirement to be measured against the worst performing SIMD quintile. Most CH(C)Ps within NHSGG&C worst performing quintiles were SIMD 3,4 and 5. NHS Boards were funded through the Dental Bundle as part of the Child Smile programme for delivery in 20% of the NHS Board's schools and nurseries in the lowest deprivation quintile (SIMD 1). NHSGGC delivered fluoride varnishing applications in nearly 50% of SIMD 1 schools which was in excess of what funding was available. It was considered that within Glasgow City, restricting access to 20% of schools would be unlikely to address assessed need. The Board does not deliver the programme in schools and nurseries in East Dunbartonshire, West Dunbartonshire or East Renfrewshire as there were no schools with numbers of SIMD 1 children. If it did, this would give schools and nurseries priority over those selected by needs assessment in CH(C)Ps with larger numbers of SIMD 1 and 2 populations. The positive aspect was ensuring that targets were being met in the most at-risk populations and was therefore helping address the oral health inequalities gap. For those schools and nurseries outwith the priority areas, the delivery of the programme relied entirely on general dental practitioners who had been paid for their participation in the Child Smile Programme. There had been limited success in delivering the programme across Scotland despite efforts being made to engage with the general dental practitioners. The Director responsible for oral health was taking steps to ensure best efforts were made to meet this challenging target however members did acknowledge and welcome the prioritisation of children in the SIMD 1 category and the impact this was having on the inequalities gap.

Ms Brown raised the Exception Report produced on the percentage of patients waiting longer than 18 weeks to access psychological therapy, in particular some of the factors said to have affected performance. The issue of annual leave trends was viewed as a capacity issue at particular times and overall expectations were that the 18 week target by December 2014 (which was in line with the HEAT target delivery date) remained on track. Mrs Hawkins advised that there were up to 86 teams delivering this very specialised service across Primary Care, Mental Health and Acute Services. Demand and capacity issues were being considered for each team and the redirection of resources would be possible within the teams if this was required to meet the 18 week target by December 2014. Mrs Hawkins did agree that she would look at the number of teams to see if a rationalisation of teams would assist although she did indicate that some teams in the South of Glasgow had already been rationalised. Ms Renfrew added that the future reports would show the changes in the longest waits and the changes in the numbers of patients waiting over 18 weeks, including a narrative to explain both.

Director of Corporate Planning & Policy

Councillor Lafferty highlighted the significant percentage improvement in the number of delayed discharges although he was disappointed to see that the target had not yet been met. Ms Renfrew advised that welcome improvements were being made but also that a significant number of patients being assessed as not requiring hospital care for their needs were still being delayed within a number of hospitals. She explained that the baseline for the calculation had been 2009/10 and there had been a significant increase in delayed discharges within Glasgow City during 2010/11. Continued improvement was expected as a result of Glasgow City CHP's work with the City Council.

NOTED

45. SCOTTISH PATIENT SAFETY PROGRAMME - REPORT

There was submitted a paper [Paper No. 13/33] by the Medical Director updating

the Committee on the Mental Health Programme – the Hospital Standardised Mortality Ratio (HSMR) and the Early Warning Scoring (EWS) systems.

The programme for Mental Health would be four years with the overall aim of systematically reducing harm experienced by people using Mental Health Services. This would be carried out by supporting frontline staff to test, gather real-time data and reliably implement interventions. A steering group, chaired by the Lead Associate Medical Director for Mental Health, had been established to coordinate and support the programme.

The national approach of measuring hospital mortality – HSMR – was established in 2009 through the Scottish Patient Safety Programme. It was calculated for all Acute inpatient and day case patients admitted to all specialties (medical and surgical but excluding obstetrics and psychiatry) based on hospital discharge summaries and linked to death registrations from the National Records of Scotland. The calculation took account of patients who died within 30 days from hospital admission including deaths which occurred in the community (out of hospital deaths). The factors which affected hospital mortality were variable across each hospital and the community it serves. It used a risk-based model to estimate the predicted probability of death within 30 days of admission from the overall national experience in 2007. It does not however, adjust for all clinically relevant characteristics which define risk in the patient case mix of individual hospitals over time. Because it uses national averages this can cause some distortions when applied at individual hospital level. It was helpful in supporting local discussion as to whether a hospital was able to demonstrate an outcome of SPSP implementation and other measures in reducing mortality.

Specifically in relation to the Royal Alexandra Hospital, a concern had been raised previously that it had not been reducing HSMR in line with the national average. The NHS Board and its governance committees had received reports on the effective management process and the confirmation of acceptability by Healthcare Improvement Scotland on reducing the HSMR at the Royal Alexandra Hospital. It was planned that the report would be submitted to the June 2013 Board Meeting in order to discuss the concerns raised.

Within NHSGG&C all hospitals as at September 2012 had an HSMR of <1 and all had observed a >10% reduction within the reporting period. Ms Brown noted the need to continually review all factors associated with the HSMR data and had noted that the Royal Alexandra Hospital, while improving, was doing so at a slower rate than other hospitals within NHSGG&C.

NOTED

46. INFECTION PREVENTION AND CONTROL SERVICE – REPORT: APRIL 2013

There was submitted a paper [Paper No: 13/34] by the Medical Director covering the Board-wide infection prevention control activity. The report was on an exception reporting basis only as the full report was submitted to each NHS Board meeting.

The HEAT target for Staphylococcus Aureus Bacteraemia (SAB) for 2013 was 26 cases of SABs per 100,000 acute occupied bed days. Dr Armstrong advised the Committee that all efforts had been made to meet the HEAT targets at the end of March 2013 and whilst the validated results were awaited, she realised that with an

influx of admissions to hospitals, this may just have impacted on meeting this target on this occasion. In relation to Clostridium Difficile infection, the rate within NHSGG&C was 17.8 per 100,000 occupied bed days which placed the Board below the national average of 26.7 and well below the 2013 HEAT target of 39.

Dr Armstrong highlighted the outbreaks/incidents which had occurred at the Inverclyde Royal Hospital and Royal Alexandra Hospital as well as the Novovirus outbreaks across NHSGG&C. She drew attention to the information contained on the chlorine-based detergent usage within hospitals and the discussions which had been undertaken with the orthopaedic consultants at Gartnavel General Hospital in relation to hip and knee arthroplasty surgical site infection concerns and the comparisons made with the same service at Glasgow Royal Infirmary. No differences had been found, however the Infection Control Team had agreed to perform a third round of data analysis looking at an historical period agreed by the orthopaedic team, covering 1 July 2011 and 31 January 2012. Again, there was no significant statistical difference in surgical site infection rates at Gartnavel General Hospital. Ms Grant advised that the range of improvements had been made at the Decontamination Unit and active monitoring was continuing with reports being submitted to the Operational Management Group every 2-3 months.

NOTED

47. CLINICAL RISK MANAGEMENT REPORT – SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS

There was submitted a paper [Paper No.13/35] by the Medical Director on adverse clinical incidents. The report on adverse clinical incidents had been displayed on two separate charts in order to highlight the position within Acute Services and separately within Partnerships.

Dr Armstrong advised members of Healthcare Improvement Scotland's visit last week and discussions around the Significant Clinical Incident Policy and Incident Reviews. A report on the outcome of the meeting was awaited however it was clear that there was emphasis on learning across the organisations, families' involvement in the process and Non-Executive Members involvement. With anything from 160-200 Significant Clinical Incident Reviews per annum, the challenge would be ensuring that the correct processes were in place which provided assurance to NHS Board members about the steps taken to ensure learning across the organisation, leading to improvements and better outcomes. The current arrangement was based on a no-blame culture and learning shared to ensure improvements in services as a result of clinical incidents. That challenge and the involvement of families at an early a stage as possible could present some difficulties for clinical staff especially as some cases could lead to future Fatal Accident Enquiries or legal claims.

Mr Fraser asked about the intentions of Non-Executive Members' involvement and Dr Armstrong advised that this had included the SPSP walk-rounds within Acute Services, assurances about the Clinical Governance processes and reporting to the Quality and Performance Committee/Board. The challenge for NHSGG&C was to provide assurance to members about the outcomes and discharging the learning without all 160/200 cases being presented to a Committee individually. A tabulation of key themes and explanations was one possible route together with utilising the Board's Clinical Governance Forum, with only significant cases being reported direct to the Quality and Performance Committee. These points would be considered in completing the review of the Significant Clinical Incident Policy prior to its submission to the July Quality and Performance Committee meeting for approval,

although it was recognised that it would be intrinsically linked to the Healthcare Improvement Scotland guidance on the National Framework for managing learning from adverse events. Mr Sime asked Dr Armstrong to include within her review the previous role undertaken by the Clinical Governance Committee to ensure its previous role was adequately covered in the new arrangements. **Medical Director**

Dr Armstrong highlighted an ongoing investigation and drew members' attention to the active Fatal Accident Enquiries.

NOTED

48. 2013/14 FINANCIAL PLAN

There was submitted a paper [Paper No. 13/43] from the Director of Finance in which he presented the Draft 2013/14 Financial Plan for comment following the agreed review undertaken by the Corporate Management Team.

The Draft Plan had been discussed at the NHS Board's Away Sessions in mid-January 2013 and further discussed by members at the NHS Board Seminar in May 2013. The paper had been revised to take account of comments received from NHS Board members and the Corporate Management Team. It provided an overview of the key elements of the plan including the key assumptions and risks and plans to address the cost savings challenge which the NHS Board faced in order to achieve a balanced financial outcome in 2013/14.

Mr James took members through each section of the Report and described each table in turn, recognising the titles of each table may change prior to submission to the NHS Board on 25 June 2013. Mr James answered members' questions in relation to the reviews underway including IT, the assumptions made on the under recovery from other Boards in relation to cross-boundary flow, the progress made with the National Resource Allocation Committee assumptions, the process and timescale of the presentation of the Financial Plan, the prescribing cost growth projections for 2013/14, the steps taken in achieving greater efficiency in reducing energy consumption, the assumptions relating to auto-enrolment and lastly he agreed to revise the wording within the paper in relation to staff turnover ratios and filling of vacancies. **Director of Finance**

DECIDED

- That the NHS Board's 2013/14 Financial Plan be approved and presented for ratification at the NHS Board meeting on 25 June 2013. **Director of Finance**

49. PROPOSED CAPITAL PLAN – 2013/14 to 2015/16

There was submitted a paper [Paper No: 13/44] from the Director of Finance setting out the proposed Capital Plan for 2013/14 to 2015/16.

Mr James advised that SGHD had confirmed that the initial gross capital resource allocation for the NHS Board was £295.289m with the new Southside Glasgow Hospitals accounting for £218.624m.

Councillor McIlwee asked about the allocation for cladding at Inverclyde Royal Hospital and Mr McIntyre advised that while the current reviews continued to try and determine the extent of the problems with the cladding at this hospital, the sum

set aside was to ensure that the building was maintained in a safe and wind and watertight state.

In response to a question from Mr Lee, Mr James agreed to review whether the balance sheet should include the Hub Initiatives as these were of a capital nature, although revenue-funded. **Director of Finance**

DECIDED

1) That, the allocation of Capital Funds for 2013/14 pending ratification at the NHS Board meeting on 25 June 2013, be approved; **Director of Finance**

2) That, the current indicative allocations for 2014/15 and 2015/16, be noted;

3) That the Joint Capital Planning and Property Group be delegated the authority to allocate any additional available funds against the 2013/14 Capital Plan throughout the year. **Director of Finance**

50. FALLS WITHIN HOSPITALS – GOVERNANCE REPORT

There was submitted a paper [Paper No. 13/36] by the Nurse Director providing an overview of the approach within NHSGG&C in reviewing incidence of falls within hospitals.

At the September 2012 meeting of the Quality and Performance Committee, a paper had been presented describing the work undertaken within the Acute Services Division to address the incidents of falls within hospitals. The Committee had asked that the next update include information on the incidence and governance arrangements of falls within inpatient settings in Partnerships. Falls within Acute Services were reviewed through Local Directorate Governance arrangements and the Acute Services Division Falls Governance Group with six monthly reports to the Acute Services Clinical Governance Forum. Within Partnerships the incidence of falls was reported and reviewed at Local Governance Groups within each Service Area. A composite report on a six monthly basis through the System-Wide Governance arrangements incorporating Older People's Mental Health, Adult Mental Health, Addictions and Learning Disability Services was produced.

The number of falls had reduced within Acute Services by 4.5% in the previous year and by 8.8% in Partnerships. There had been a welcome increase in referrals to the Acute Service Divisions Hospitals Falls Prevention Service (which provided staff training and specialist advice on the identification and prevention of falls) and this had demonstrated that patients were more readily being assessed for the risk of falling.

The Nurse Director would chair a multi-disciplinary Falls Steering Group, to be established shortly and one of its early priorities will be to agree the most appropriate method of setting trajectories towards preventing the incidence of falls in hospital settings. **Nurse Director**

Members welcomed the NHS Board-wide approach and the Governance in place to review the incidence of falls and steps taken to prevent falls in future.

NOTED

51. OLDER PEOPLE IN ACUTE CARE: HEI INSPECTION SUMMARY REPORT

There was submitted a paper [Paper No. 13/37] from the Nurse Director which presented a summary report on the care of older people in Acute Hospitals Inspections and progress with improvement actions. Healthcare Environment Inspectorate carry out a programme of inspections in order to provide assurance that the care of older people in Acute Hospitals was of a high standard and they gave special consideration to:-

- Treating older people with respect, compassion and dignity;
- Dementia and cognitive impairment;
- Preventing and managing falls;
- Nutritional care and hydration;
- Prevention and management of pressure ulcers.

The report set out the inspections undertaken to date together with the findings' key themes which included areas for improvement and areas of strength.

The report was welcomed by members and it was agreed that a regular report would be sent to Committee, which would incorporate future reports' comparative data. **Nurse Director**

NOTED

52. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 15 APRIL 2013

There was submitted a paper [Paper No: 13/38] in relation to the Board Clinical Governance Forum meeting held on 15 April 2013.

NOTED

53. PRISON HEALTHCARE - UPDATE

There was submitted a paper [Paper No. 13/39] from the Director of Glasgow City CHP on the progress of delivering of healthcare within prisons in Scotland since it became the responsibility of the NHS in November 2011. This report provided an update across the full range of services, governance matters and ongoing challenges. A broad range of services were delivered within each prison including GP, dental, addictions, mental health, chronic disease management, sexual health, podiatry, pharmacy and optometry.

Ms Brown commented on the report from the National Prisoner Healthcare Network in relation to the new paragraph entitled "Social Care". She would like the description of social care to be revised in future reports. **Director of Glasgow City CHP**

Ms Micklem found the report comprehensive and informative and was encouraged at the undertaking of the health needs assessment of the prison population which had been commissioned in 2011 and reported in 2012. She asked about the planning for sexual behaviours within prisons and associated risks. Mrs Hawkins indicated that this had been identified as an issue under the health needs assessment. Ms Renfrew, who chaired the Sexual Health Steering Group, indicated that there was a stigmatising issue for prisoners and more work was being undertaken to understand the complexities of these areas and what actions could best be taken to meet the issues and challenges faced by prisoners.

Dr Armstrong recognised the issue of mental health services within prisons and also the need to support better discharge planning to avoid the same prisoners returning to prison time and time again. It was also noted that Methadone accounted for the majority of supervised medicine activity and currently within Barlinnie there was an average of 300 prisoners receiving supervised Methadone at any one time. Mrs Hawkins advised that Addiction Services were delivered jointly between the NHS and Phoenix Futures who are a voluntary sector organisation. This service included assessment of addiction needs, one-to-one and group based interventions and harm reduction interventions. However next month a revised addiction model would be introduced to ensure that service delivery in the prison setting was consistent with the outputs for the addictions clinical services review activity and also better supported the through-care needs of prisoners when they were moving back into their communities. Dr de Caestecker added that she was a member of a group looking at the holistic care for vulnerable women within prisons and that they were at an early stage of scoping and then planning future services. On Mental Health, Mrs Hawkins advised that a draft report on this issue about reshaping the services as part of a national vision had been prepared and would be considered at the appropriate time.

The first 18 months had been an opportunity to assess those areas in which change can be enacted and the service was now steadily adapting towards new models of care and filling gaps in service provision. The focus of activity now has been on improving on through-care and it was anticipated that this will materialise as the service further develops.

NOTED

54. ADULTS WITH INCAPACITY REPORT OF SUPERVISORY BODY FOR 2012

There was submitted a paper [Paper No: 13/45] by the Director of Glasgow City CHP presenting the Annual Report for the calendar year 2012 covering discharge of the Board's obligations under Part IV of the Adults with Incapacity (Scotland) Act 2000 to make arrangements for the management of funds of those patients resident in our hospitals and residential establishments who lack the capacity to make decisions about their own finances.

The role of the Supervisory Body was to oversee the functions of the Board which relate to the management of patients' financial affairs where other possible means such as Guardianship Orders or Power of Attorney have not been obtained. The annual report produced by the supervisory body was submitted to the Committee for comment based on recommendations made by the internal auditors following the review undertaken in 2009.

NOTED

55. WHAT ARE WE DOING ON INEQUALITIES AND WHAT ARE THE GAPS AND CHALLENGES?

There was submitted a paper [Paper No: 13/40] from the Director of Corporate Planning and Policy which summarised the presentation and discussion at the NHS Board Seminar in April 2013 on tackling inequalities and proposed a set of further actions which built upon existing work.

Dr de Caestecker, in highlighting a number of the actions proposed, made particular reference to the development of a more systematic approach to understanding service use (including preventative services) in relation to the need and the following up of "did not attend" data; the focus on influencing Scottish Government Policy on primary care so that the contribution primary care could make to tackling inequalities was maximised; ensure that equalities measures were given the same prominence as other targets; to ensure that the NHS Board's papers reflected equalities dimensions systematically; retest the focus on early years in NHS Service Delivery and Partnership Working and lastly, consider whether maximum synergy has been achieved between NHS Board work and academic research and maximise joint opportunities for advocacy.

Ms Brown commended the focussed approach to the actions and Ms Micklem complimented the comprehensive summary and actions to be undertaken. She enquired about the accountability to deliver the actions in terms of reporting to the Committee and frequency of reporting and she particularly welcomed the review of Health Improvement teams in Community Development. Ms Renfrew agreed that there would be a regular reporting cycle back to the Committee on the progress against the specific identified actions.

Director of Corporate Planning & Policy

NOTED

56. QUALITY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: JANUARY – MARCH 2013

There was submitted a paper [Paper No: 13/41] from the Nurse Director in relation to the actions taken in connection with the recommendations of the full investigations reports and decision letters of the Scottish Public Service Ombudsman. It was highlighted that there had been one full report in the quarter from January to March 2013 (enclosed with the paper) and 15 decision letters in addition to reporting on the two outstanding actions from the July to September 2012 quarterly report in relation to recommendations affecting a GP practice and dental practice.

Mr Finnie expressed his ongoing concern that Ombudsman investigative reports and decision letters were produced in situations where the NHS Board has completed the local resolution stage of the NHS Complaints Procedure and believed that it had handled the complaint adequately. Mr Calderwood acknowledged disappointment that there was a high number of upheld elements to the Ombudsman's Reports and decision letters and the highlighting of lessons to be learned by the investigating organisation. He acknowledged that not all recommendations related to failures in the adequate delivery of clinical services but it had caused him to wonder if NHSGG&C still remained too defensive on occasions when responding to complaints. Ms Grant advised that within the Acute Services Clinical Governance structure, steps were being taken to identify themes, identify where responses could have been better and possibly less defensive and provide greater support to the NHS Complaints process. She had also introduced an external review between different Directorates to ensure that a fresh approach was taken when a complainant was dissatisfied with our initial response.

Ms Brown welcomed the steps described by Ms Grant and hoped that in future we would see less elements of complaints upheld by the Ombudsman. Ms Crocket talked about the meeting with the Ombudsman in February 2013 and the intention to bring about closer links between complaint managers and the Ombudsman teams to try and ensure better complaints handling and where gaps may exist in handling complaints within NHSGG&C. It was important to support managers, but also to

learn lessons from complaints in order to bring about service improvements.

NOTED

57. QUALITY POLICY DEVELOPMENT GROUP MINUTES – 28 FEBRUARY 2013

There was submitted a paper [Paper No. 13/42] enclosing the minutes of the Quality Policy Development Group meeting of 28 February 2013.

NOTED

58. STAFF GOVERNANCE COMMITTEE – MINUTES OF MEETING HELD ON 19 FEBRUARY 2013

There was submitted the minutes of the Staff Governance Committee meeting held on 19 February 2013.

NOTED

59. MEDIA COVERAGE – MARCH/APRIL 2013

There was submitted a paper [Paper No: 13/46] by the Director of Corporate Communications highlighting outcomes of media activity for the March-April 2013 period. The report supplemented the weekly medial roundup which was provided to NHS Board members every Friday afternoon and summarised media activity including factual coverage, positive coverage and negative coverage.

NOTED

60. ANALYSIS OF LEGAL CLAIMS – MONITORING REPORT (YEAR-END REVIEW 2012/2013)

There was submitted a paper [Paper No: 13/47] by the Head of Board Administration setting out the monitoring report on the handling and settlement of legal claims within NHSGG&C in the period 2012/13.

NOTED

61. NEW SOUTHSIDE GLASGOW HOSPITALS – PROJECT UPDATE –– STAGES 2 & 3

There was submitted a paper [Paper No: 13/48] by the Project Director of the New South Glasgow Hospitals 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 relation to stage 2 Mr Seaborne advised that good progress continued to be made in reviewing and agreeing the design of the layouts and systems for the two hospitals. The design review process remained on programme and the process to detail equipping and programme of equipment was ongoing for all groups.

In relation to stage 3, as at 5 May 2013, 110 weeks of the 205 week contract had been completed and the project remained within timescale and budget. Mr Seaborne provided members with further images highlighting the progress of both hospitals over the last 12 months.

In relation to Car Park 1, site preparation works had commenced in March with the relocation of the subcontractors compound to an area North of the new Adult Hospital. The piling mat was completed and the subsequent piling activities commenced on-site on 13 May 2013. In relation to Car Park 2, work continued to develop the design for Car Park 2 which would dovetail with the construction of the new VIE Oxygen installation adjacent to the physically disabled rehabilitation unit. Brookfield had confirmed that they hope to start work on the VIE Plant in the autumn of 2013 and this would be completed before the start of works to construct Car Park 2.

In addition to the SGHD Capital Investment Group Approval of the outline business case for the Teaching and Learning Centre, the planning application had also now been submitted to Glasgow City Council in March and it was anticipated that the full business case would be submitted to NHS Board members in September 2013 for approval. **Project Director**

In October 2012 NHSGG&C and Brookfield Multiplex won the Government Opportunities Excellence in Public Sector Awards – Sustainability and Corporate Social Responsibility Initiative of the Year at the Scottish Government Opportunity Awards ceremony. In addition the NHS Board and Brookfield Multiplex also won the UK National Government Opportunities Award for best supplier engagement. NHS Board members congratulated Mr Seaborne and his team on achieving such prestigious awards.

Mr Ross updated members on the change control process and comprehensive events and it was noted that there had been no compensation events since February 2013.

Mr Seaborne advised that the Acute Services Strategy Board had considered an approach from Brookfield Multiplex to proceed to close out and cap the Board Inflation Liability within the contract by agreeing a £12m (including VAT) compensation event to the contract with Brookfield. The Acute Services Strategy Board and Chief Executive supported the recommendation that this offer be accepted and Mr Seaborne highlighted the background to this matter together with the inflation forecast. The agreement at the time of procurement was that bidders were to include a baseline allowance of 2.5% per annum inflation and the NHS Board would accept the risk of inflation exceeding 2.5% over the duration of the contract (2010-2016). As part of the Hospitals Stage 3 instruction to proceed, the NHS Board negotiated a change to baseline calculation period to 2011-2016, mitigating the 2010 inflation impact which was significantly above the 2.5% baseline. In order to provide surety on potential inflation recovery for both parties, Brookfield had proposed a compensation value of £12m (including VAT) to be considered now and cap the Board's inflation liability. All other contract terms would remain unchanged. The current allocation for inflation in the risk register was £16.5m and in considering this matter, the movements in HM Treasury Future Forecasts and variations in historic forecasts versus actual, there had been and continued to be volatility in potential inflation forecasts.

Mr Winter was supportive of accepting the recommendation as long as it could be contained within the allocation for 2013/14 and was consistent with the contract terms. Mr Calderwood assured Mr Winter on both points and indicated that it had

the potential of also releasing £4.5m from the contract for other schemes.

DECIDED

1. That the Progress Report on Stage 2 (Design and Development of the new hospitals) and Stage 3 (Construction of the Adult and Children's Hospitals) be noted.

2. That officers be instructed to proceed to close out and cap the NHS Board's Inflation Liability by agreeing a £12m (including VAT) compensation event to the contract with Brookfield Multiplex be approved. **Project Director**

62. PROPERTY ASSET MANAGEMENT STRATEGY (PAMS)

There was submitted a paper [Paper No: 13/49] by the Director of Facilities enclosing a copy of the NHS Board's Property and Asset Management Strategy for April 2013 to March 2017. This was the third strategy and was an accumulation of both physical site surveys and desktop reviews. It was a live document and was continually reviewed and updated by the Property Team to reflect the investment and improvements from the Board's Capital Plan and the condition of assets relative to their age and use. The PAMS documentation would be a key element used in determining future capital investment strategies by the NHS Board and SGHD.

In the last five years the NHS Board has significantly improved its estate assets and has delivered a new Beatson Oncology Centre, two ambulatory care hospitals at the Victoria and Stobhill sites, a new South Glasgow Laboratory complex, a medium secure unit at Stobhill, the new Gartnavel Royal Hospital and new health centres at Renfrew and Barrhead. The developments in 2013 and 2014 will see the opening of the new Alexandria and Possilpark Health Centres, the completion of the major refurbishment of the new Lister Laboratories at Glasgow Royal Infirmary and, in 2015, the new Southside Glasgow Hospital will be commissioned and four replacement health and care centres built through the hub initiative at Maryhill, Woodside, Gorbals and Eastwood. In addition to these new facilities, the estate will herald the closure of the Victoria Infirmary and Mansionhouse Unit, Western Infirmary, Royal Hospital for Sick Children and the corresponding health centres at Maryhill, Woodside, Gorbals and Eastwood.

It was recognised that the Board was in a very good position to identify how to improve the overall rating of its Acute Hospital estate through the completion of the new Southside Glasgow Hospital, the upgrading of retained estate and the rationalisation out of a number of older and less compliant premises. There will however still be a number of areas where, in retained estate, fully compliant spaces and services cannot be delivered due to the physical constraints in the properties. However these will be maintained to a safe and effective standard for patient care.

In the context of GP premises, the challenge will be to support where legislatively and financially possible the practices through improvement grants and to encourage/demand improvements to an acceptable standard for those areas requiring individual practice financed improvements. In addition the PAMS document also considered the Board's position in the context of I M and T, vehicles and equipment.

Members welcomed the excellent overview of the Property Asset Management Strategy and recognised the benefits accrued by the large capital investments made within the NHS Board's estates over the last few years. It was also recognised the challenging position that the NHS Board would face in future years in terms of the

allocation of Scottish Capital Funds.

Mr Finnie enquired about how officers would manage the end point of the current PAMS document and move into the next programme. Mr Calderwood acknowledged the point and described the current PAMS document as one based on decisions taken some ten years ago in relation to the Acute Services Strategy and other reviews. The Clinical Services Review and working together with other public sector organisations, particularly Local Authorities, would be essential in moving forward to securing better premises for the provision of joint and individual services. Major challenges remained in connection with providing facilities at the Tower Block at Glasgow Royal Infirmary and other health care buildings constructed in the 1970s/1980s.

DECIDED

- That the NHSGG&C Property Asset Management Strategy 2013-2017 be received and endorsed. **Director of Facilities**

63. CAPITAL PLANNING AND PROPERTY GROUP MINUTES OF MEETING HELD ON 25 MARCH 2013

There was submitted a paper [Paper No: 13/50] enclosing the minutes of the Capital Planning and Property Group meeting of 25 March 2013.

NOTED

64. DATE OF NEXT MEETING

9.00am on Tuesday 2 July 2013 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1.00pm