

DRAFT

QPC(M)13/04
Minutes: 65 - 88

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 2 July 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)

Dr C Benton MBE

Mr I Fraser

Cllr M Kerr (from Minute 69)

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 (to Minute 78)

Ms R Crocket

Dr L De Caestecker (to Minute 70)

Dr R Finnie

Mr P James

Mr R Reid

Mr A O Robertson OBE (to Minute 78)

Rev Dr N Shanks

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

Mrs E Borland	..	Head of Planning & Performance, Glasgow CHP – North West Sector (to Minute 79)
Ms C Curtis	..	Health Improvement Lead – Acute (to Minute 70)
Mrs J Grant	..	Chief Operating Officer
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP (Minute 79)
Mr D Loudon	..	Director, Facilities (to Minute 78)
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting (to Minute 69)
Mrs J Murray	..	Director, East Renfrewshire CHCP (to Minute 79)
Ms C Renfrew	..	Director of Corporate Planning & Policy
Mr D Ross	..	Director, Currie & Brown UK Limited (to Minute 78)
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (to Minute 78)
Dr D Stewart	..	Lead Director for Acute Medical Services

65. APOLOGIES

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

66. DECLARATIONS OF INTEREST

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

67. MINUTES OF PREVIOUS MEETING

On the motion of Mr D Sime and seconded by Mr K Winter, the Minutes of the Quality and Performance Committee Meeting held on 21 May 2013 [QPC(M)13/03] were approved as a correct record.

68. MATTERS ARISING

(a) Rolling Action List

- (i) In relation to Minute 49 – Capital Plan 2013/14 – 2015/16 – the Convenor advised that the Outline Business Case for Eastwood Health and Care Centre contained information which confirmed that revenue-funded Hub initiatives were included in the balance sheet. The Director of Finance confirmed this to be the case.

NOTED

(b) EQIA for NHSGGC Access Policy – Actions Update Report

In relation to Minute 25 – Integrated Quality and Performance Report – a request had been made for an update on the equalities issues raised in the Patient Access Policy and how these were being addressed. There was submitted a paper [Paper No 13/52] by the Director of Corporate Planning and Policy which set out an Action Plan on how these issues were being taken forward within defined timescales.

In addition, a further process was underway through the GP Interface Group to improve referral processes between Primary Care and Secondary Care. This would include enabling GPs to target support to patients who they believe may be likely to not attend appointments.

Ms Micklem welcomed the report and ongoing monitoring and enquired as to what the information was telling us about services and asked that this be included in a follow-up report to the Committee. Ms Renfrew agreed to include this aspect in a follow-up report to the Committee in six months' time.

**Director of
Corporate
Performance &
Policy**

(c) Western Infirmary Site B: Progress Update

In relation to Minute 4(b) – Western Infirmary: Site B: Update – the Chief Executive advised that the final Heads of Agreement had been exchanged with the University of Glasgow and he expected the sale to conclude during the course of this month. He would confirm the outcome at the next meeting of the Committee.

Chief Executive

NOTED

69. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No. 13/53] from the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHS

Greater Glasgow and Clyde's performance. As had been reported previously, from 1 April 2013, the tolerance level applied to the performance status had been reduced from 10% to 5%. This meant that performance that was 5% outwith meeting the trajectory/target was rated as red and performance that was within 5% of trajectory was rated as amber. 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; 9 as amber (performance within 5% of trajectory) and 8 as red (performance 5% outwith meeting trajectory). The areas of key performance change since the last report included:-

- Suspicion of cancer referrals (62 days) had moved from green to amber;
- Carbon emissions had moved from amber to red;
- New outpatients; maximum 12 week wait had moved from red to green;
- Freedom of Information requests completed within 20 days had moved from amber to green.

Ms Renfrew advised that it was intended to bring a more detailed report to the Committee at the next meeting in relation to waiting times for access to psychological therapy, especially in light of the improved data highlighting variances in performances and, in some areas, excessive waits. This was welcomed.

**Director of
Glasgow CHP**

Mr Finnie asked about the impact of the Change Fund in relation to delayed discharges and acute bed days lost to delayed discharge, particularly in relation to the likelihood of the Change Fund not being sustained at current levels. Mr Calderwood advised that an initial allocation across Scotland amounted to £70m and an additional £10m was added to this in the second year and the overall intention was that the Change Fund be a three year programme. A Ministerial Task Force had been established to consider how the £80m per annum could be best used in future and these discussions were underway. Current monitoring within NHSGGC in relation to the use of the Change Fund was undertaken at local CH(C)P Committee level and at the Organisational Performance Review meetings which were held twice per annum. Benefits had been realised by utilisation of the Change Fund as had been noted in the reports to Committee on improving performances under delayed discharges. In addition the Fund had also been used to improve the quality of services, capacity building and other similar initiatives. If any decision was made to withdraw or redirect the funds, the NHS Board would need to consider the implications in terms of financial planning and consideration of priorities. On a separate point, it was reported that the SGHD were clarifying the intention that there be no reduction in Elderly Care beds for the over-75s at a time of increasing demand and a growing elderly population.

Mr Finnie also raised his concerns at the only actions identified within the Carbon Emissions exemption report as they seemed to relate to future capital investment decisions. Mr Calderwood acknowledged this point and indicated that a paper would be brought to the Committee shortly on the full range of actions being undertaken within the Carbon Management Plan in order that members could scrutinise the different individual actions being undertaken and the moves to achieve the carbon reduction target of 15% by March 2016.

**Director of
Facilities**

Mr Winter raised the increasing use of overtime and bank staff in recent months. Mr Calderwood indicated that the Corporate Management Team monitored this area and would be concerned if excessive use was being made of bank staff or overtime which masked concerns about staffing levels. The issues to date in relation to the additional overtime and use of bank staff had related to service redesign changes and unscheduled demand. He agreed that he would ask the

**Director of
Human Resources**

Director of Human Resources to pull together a more detailed report from Operational Directors for further scrutiny by the Committee.

Councillor Lafferty asked if there was more detail available on where the sickness absences were occurring within the organisation. It had been acknowledged that the HEAT target was unlikely to be achieved although whilst it was a tough target, it had focussed attention on this area and had resulted in a lot of significant work in improving absence management arrangements and sickness levels within the organisation. Mr Sime reminded members that the Staff Governance Committee had been remitted to review and take all action in relation to the sickness absence rate.

Dr Armstrong advised that the MRSA target of 26 cases per 100,000 acute occupied bed days would be narrowly missed by NHSGGC as it seemed its validated figure would be 26.8 bringing it into the amber category of performance status.

Members welcomed again the detailed analysis made possible by the information contained within the Integrated Quality and Performance Report.

NOTED

70. HEALTH PROMOTING HEALTH SERVICE: ACTION IN HOSPITAL SETTING (CEL 01 2012) – ANNUAL REPORT

There was submitted a paper [Paper No: 13/58] from the Director of Public Health providing a copy of the Annual Report – 2012/13 on Health Promoting Health Service: Action in Hospital Setting. The Annual Report had been submitted to Health Scotland on behalf of the Government on 30 April 2013 and the document provided a summary of the year 1 position and identified priorities for progression in year 2.

The report had provided comprehensive evidence in relation to SGHD's performance measures in relation to core actions i.e. smoking; alcohol; breast feeding; healthy working lives; sexual health; food and health; physical activity and active travel within hospital sites. In addition further detail was provided in relation to a staff management programme and research to engage with hard-to-reach staff groups. Ms Claire Curtis, Acute Health Improvement Lead, attended to assist with members' questions.

Mr Finnie welcomed the successful launch of the campaign to stop smoking but he would like further information on how these initiatives could be sustained. Dr de Caestecker advised that a lot of work was ongoing with the media to ensure continued publicity within this area and the intention was that on a quarterly basis to look at the impact of the initiatives, evaluate their success and make changes going forward. This would include changing posters and messages within hospital entrances and clinic/ward areas and she highlighted that regrettably, three smoke-free wardens had recently resigned from their posts following unacceptable behaviour from members of the public who had been approached within hospital sites to stop smoking. No smoking was a key target for the NHS Board and therefore it would be a priority to ensure a sustained effort over a long period of time would be maintained.

Rev Dr Shanks asked for more information about the acute patient panels and Ms Curtis explained that they comprised of 20-30 patient representatives and were

subject to six monthly reviews to ensure effective public engagement was maintained in trying to ensure that every healthcare contact was a health improvement opportunity.

Members welcomed sight of the first Annual Report.

NOTED

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

There was submitted a paper [Paper No. 13/54] 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 highlighted the recent case where valuable lessons had been learned and drew members' attention to the active Fatal Accident Enquiries, in particular to a current case involving a pregnant woman who had been admitted to hospital with chest pains and had sadly died.

NOTED

72. REVIEWING SIGNIFICANT CLINICAL INCIDENTS POLICY AND PRACTICE

There was submitted a paper [Paper No: 13/55] by the Medical Director providing sight of the Significant Clinical Incidents Policy and giving an update on Healthcare Improvement Scotland's approach.

It had been previously stated that the Significant Clinical Incidents Policy would be submitted to the Quality and Performance Committee in July for approval. However as has been previously recognised, this was also dependent on Healthcare Improvement Scotland (HIS) publishing the new National Clinical Incident Framework. The Framework has not yet been published and therefore the Significant Clinical Incidents Policy would be brought back to the September meeting, revised as appropriate, for formal Committee approval. Dr Armstrong tabled a paper setting out the process undertaken in conducting the policy review and implementation plan.

Dr Armstrong had previously reported that NHSGGC had provided extensive feedback through the national consultation from HIS on building a national approach to learning from adverse events through reporting and review. Complementary to this development process, HIS had now completed their inspection visit to review NHSGGC's arrangements and to audit samples of significant clinical incidents. This report was now due for publication and comments had been fed back on an embargoed version of the report to ensure accuracy and proper clarity around some issues.

Dr Armstrong will provide NHS Board members with a copy of this report once available.

Medical Director

Ms Micklem commented that the policy on the management on Significant Clinical Incidents was helpfully balanced in terms of the appropriate rigour and

transparency required together with informing and involving patients and relatives. She believed that it was crucially important to maintain and retain the public's confidence in our services particularly with the processes which are then undertaken when something does go wrong.

Mr Finnie enquired about the Non-Executive member engagement particularly in relation to what form, what level and who would decide. Dr Armstrong advised that national work was currently underway to define the Non-Executive member involvement; currently that role was undertaken on a strategic basis at the Quality and Performance Committee and she fully understood members' comments previously that it would not be possible for Non-Executive member involvement in all circa 200 cases of significant clinical incidents per annum. It was likely that a summary of the key areas, key risks and trends and outcomes would be a possible way forward however once the national group had reported. It would then be for Non-Executive members to determine what role they would like to undertake against whatever national framework is set for member involvement. Mr Sime welcomed the attempts to ensure that there were no surprises by producing regular updates to members, particularly via the Communications Team. This had been very helpful and welcomed by members.

DECIDED

- (1) That the Policy on the Management of Significant Clinical Incidents be noted, revised in light of the publication of the National Clinical Incident Framework and thereafter submitted to the next Committee meeting for approval.
- (2) That the Report by HIS on their inspection visit to review NHSGGC arrangement associated with significant clinical incidents be forwarded to NHS Board members.

Medical Director

Medical Director

73. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 10 JUNE 2013

There was submitted a paper [Paper No: 13/56] in relation to the Board Clinical Governance Forum meeting held on 10 June 2013.

NOTED

74. REPORT OF THE NHSGGC FRANCIS REVIEW TEAM

There was submitted a paper [Paper No. 13/57] from the Medical Director and Nurse Director setting out NHSGGC's Review Team report into the recommendations of the Francis Report of the Mid-Staffordshire NHS Foundation Trust Public Enquiry. The Francis Report was published in February 2013 and included a description of appalling standards of care which had prevailed in the Mid-Staffordshire Hospital for a number of years. NHSGGC had set up a Review Team to undertake a comprehensive review of all 292 recommendations and take stock and reflect on the NHS Board's arrangement and practices. This was with a view to learning lessons and ensuring that the care provided by NHSGGC was of the highest quality, safe and centred on the needs of patients.

The report submitted had been reviewed by the Corporate Management Team and a facilitated event for Executive Directors, Senior Managers and Senior Clinicians

had been arranged to review the report in detail on 4 July 2013.

Ms Micklem advised that as one of the team members she had been able to attend the away-day held on 11 April 2013 and had been impressed with the depth and level of process undertaken in trying to identify the gaps and actions in order to be assured such issues could not happen within NHSGGC. It had highlighted to her the possible weaknesses in the dual role of commissioner and provider; how patient feedback was reviewed by the Quality and Performance Committee and the need to tackle the defensive culture as highlighted by previous Ombudsman reports, in handling complaints and to consider the external scrutiny role.

Mr Calderwood felt the report had been a fair distillation of the work undertaken by the team and a range of gaps and opportunities had been identified. Some issues would require a national view and some would require a more strategic and wider approach to be taken by the NHS Board in considering how best to take forward specific aspects of the report. Topics had been agreed for the facilitated event on 4 July and he looked forward to the outcome of that event. There were, however, issues that could be taken forward now, particularly around the complaints management issues and he supported early progress in such areas.

Nurse Director

Members welcomed the report and Rev Dr Shanks was pleased to see the areas of values, culture and caring and compassionate behaviours and the leadership role being highlighted as important although he recognised all were difficult to measure.

Dr Armstrong welcomed the comments and looked forward to the event on 4 July, together with good visibility with staff on the report. She would consider the issues raised and also give further thought to the external scrutiny arrangements.

NOTED

75. MEDICAL WORKFORCE PLANNING 2013/14

There was submitted a paper [Paper No. 13/59] by the Medical Director and Chief Operating Officer which described some of the key drivers which were changing the shape of the medical workforce and contributing to additional pressures which the NHS Board was experiencing. This paper was introduced by Dr David Stewart, the Lead Director for Acute Medical Services. Those key drivers were:-

- Introduction of the new junior doctors training scheme, Modernising Medical Careers in 2007;
- A change in the pattern of seniority of trainees distributed to NHS Boards via the Regional Workforce Planning Group;
- Change in the demographics of the medical workforce with more demand for flexible working practices;
- Inability to fill increasing numbers of junior doctor vacancies.

In 2012/13 the NHS Board had agreed to resource additional medical staff (consultants and specialty doctors) in the following areas, which had seen the disestablishment of 34.5 junior medical posts:-

- Emergency Medicine – 8 consultants and 1 specialty doctor;
- Anaesthetics – 16 consultants;
- Obstetrics and Gynaecology – 7 consultants.

The reductions in 2013/14 would impact on NHSGGC in paediatrics, emergency

medicine and anaesthetics and the Chief Executive and Medical Director have approved the following posts to minimise the risk to service provision:-

- 1 specialty grade doctor, 1 ANNP – Princess Royal Maternity
- 1 post-certificate of completion training clinical fellow
- 4 consultant neonatology posts
- 1 consultant – paediatric emergency medicine
- 10 locum appointments for training posts for maternity

The additional cost would be £800,000 per annum.

It was recognised that it was likely that further reductions in the junior doctors cohort would apply to the next two years. Efforts would be made to work with services in order to merge rotas, consider opportunities for shift working and reassess the overall medical workforce numbers and skill mix to mitigate any further medical workforce challenges. Members noted the actions taken to date to minimise any risk to service provision to patients.

Dr Stewart also highlighted a difficulty in terms of out-of-hours coverage for general practitioner services. This had been exacerbated during the summer months due to differential pay rates which had been offered to general practitioners to work elsewhere. As it was the NHS Board's responsibility to ensure a safe and effective service for patients in terms of GP's out-of-hours services, it had been necessary to match the differential pay rates to retain the existing GPs on the out-of-hours rotas. This had been an unfortunate outcome but the need to ensure safe and sustainable services was the Board's priority. Challenges lay ahead as the workforce now had greater choices around work life balances and workforce planning needed to take account of this moving forward. Ms Hawkins advised that there was work underway looking at the roles and responsibilities of GPs and currently within the area of the Prison Health Services, some posts have had to be filled by agency staff.

It was Mr Calderwood's intention to raise the issues highlighted by differential pay rates being used by west of Scotland NHS Boards with the west of Scotland Chief Executives to ensure a better and more effective co-operative approach was taken in future.

Chief Executive

NOTED

76. LOCAL DELIVERY PLAN – NHS BOARD CONTRIBUTION TO COMMUNITY PLANNING PARTNERSHIP

There was submitted a paper [Paper No. 13/60] from the Director of Corporate Planning and Policy highlighting the additional guidance issued by SGHD in relation to local delivery plan (LDP) contributions to community planning and single outcome agreements. NHS Boards had now been asked to reflect on the outcome of the current quality assurance of single outcome agreements and in particular the key areas for development or improvement arising from that process. This would lead to the sign-off of an additional LDP submission setting out the NHS Board's contribution to community planning single outcome agreements to be shared with SGHD by the end of September 2013. Ms Renfrew advised that a draft report on community planning therefore, would be submitted to the next meeting of the Quality and Performance Committee.

**Director of
Corporate
Planning and
Policy**

Mr Finnie enquired about the role of Non-Executive members in relation to this

area and Ms Renfrew advised that this oversight was undertaken by Non-Executive members being members of the CH(C)P Committees, who reviewed these matters at a local level.

NOTED

77. **(a) PERSON CENTREDNESS: HEALTHCARE FRAMEWORK – IMPROVING THE PATIENT EXPERIENCE AND PROVIDING CARE WHICH IS SAFE CLINICALLY AND COST EFFECTIVE**
- (b) NHS SCOTLAND PERSON-CENTRED HEALTH & COLLABORATIVE SUMMARY REPORT**

There were submitted two papers [Papers No: 13/61a and 13/61b] by the Nurse Director setting out the proposed framework to deliver person-centred health and care across NHS GGC together with the National Person-centred Health and Care Collaborative which was launched in November 2012 by SGHD. Members agreed to link both papers together in terms of their consideration and discussions.

The approach taken in improving the patient experience had been developed by the Quality Policy Development Group following a wide consultation across the NHS Board together with detailed discussions with Directors. It was intended that the launch would be backed up by an extensive programme of communication. A simplified version would be made available to all staff; local badging and process for local implementation which would include engaging with public partnership forums, patient panels and managed clinical networks; integration with the “Our Patients” theme of the Facing the Future Together programme and a series of key messages to staff to ensure that the right balance was struck between posing the improvement challenge, recognising the pressure many staff feel under, encouraging engagement and feedback, acknowledging the many examples of very good practice and encouraging staff to share what makes their job hard.

The paper highlighted under patient experience issues of access, older people’s services, patient feedback, whole system experience reporting, clear quality standards and engaging staff on improving services. The area of patient feedback was highlighted in relation to the read-across to the Francis Report and recommendations and the need to capture feedback to bring about improvements in services and report this to scrutiny Committees including the Quality and Performance Committee.

In addition, the launch of the National Person-centred Health and Care Collaborative challenged health and care systems to put the person at the centre of the service. The aim of the programme was that by 2015, health and care services were more person-centred, as demonstrated by improvements in three workstreams – care experience; staff experience and co-production underpinned by a fourth workstream of leadership at all levels.

Rev Dr Shanks recognised the connections to the messages contained within the Francis Report and welcomed the additional information which would be gathered in relation to patient feedback. He had attended with other members the Board Members visit to the Interpreting Service and had been impressed with how the service was conducted and responded to the needs of patients.

Ms Micklem welcomed this important report and was keen to see it not just as another initiative but linked into an integral part of day-to-day ongoing services.

Creative approaches to obtaining patient feedback would be welcomed and collecting patient stories was a very helpful way of sharing experiences and where relevant, identifying any inequality issues.

Ms Crocket welcomed members' comments and would report back to the Committee on the progress made in using the Person-centred Healthcare Framework to improve the patient experience.

Nurse Director

NOTED

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

There was submitted a paper [Paper No: 13/68] by the Project Director of the New South Glasgow Hospitals Project setting out the progress against Stage 2 (design and 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 has continued in finalising the remaining 1:50 design issues which were now generally limited to those items which were influenced by the procurement of specialist equipment. The project team had engaged with medical physics staff and the procurement team to undertake an exercise to identify the group 5 equipment which was to be installed in the first half of 2014. Other design work undertaken in the recent period included finalisation of floor and wall finishes, sign-off of reflected ceiling plans and the development of specialist areas and systems including aseptic, renal and medical gases. The links to both neuro and neo-natal were currently in the detailed design stage. Approval had been given to changes to be made to provide the infrastructure to support patient self check-in and patient calling technology. This involved additional data and electrical points to be installed within the adult atria.

In relation to Stage 3, as at 2 June 2013, 114 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. The structure of the adult hospital had now been completed with the final concrete pour on the last ward leg having taken place in week commencing 21 June 2013. A "Topping Out" ceremony to mark this event took place on 24 June 2013 and was attended by Alex Neil, Cabinet Secretary for Health and Wellbeing.

In relation to Car Park 1, piling work commenced on 7 May 2013 and substructure work commenced on 3 June 2013. In relation to Car Park 2, a radar survey of the build site had been completed and had not conclusively identified the location of a mineshaft but had identified other ground conditions which needed to be investigated further. Members would be kept advised of progress and any possible re-evaluation of site options in relation to Car Park 2.

Project Director

In relation to the Teaching and Learning Centre, work continued to be on programme and was progressing well, with planning approval expected in July 2013, formal target price agreement in August 2013 and the full business case would be submitted to the Quality and Performance Committee at its next meeting on 17 September 2013.

Project Director

Mr Ross updated members on the change control process and compensation events and in particular highlighted the changes to group 1 and 2 equipments lists; the decision taken at the last Committee meeting in relation to the transfer of risk for future inflation liability and the installation of additional data and power to support patient calling and patient self check-in.

Mr Seaborne then referred to Appendix A of the paper in connection with the re-provision of administration support on the South Glasgow Hospital site. He set out the outline of the proposals to re-provide administration support facilities which were currently on the Western Infirmary, Victoria Infirmary, Southern General and Yorkhill Hospital sites. These sites will close following the transfer of services to the new Southside Glasgow Hospital in 2015 and the proposed project was to re-provide 1,200 workdesks and associated facilities to support the clinical work of consultants, heads of department and other staff.

There were two options for the re-provision of the administration support, namely a new-build administration office block or the refurbishment of vacated buildings. The option appraisal undertaken with the company employed to develop design work to identify the capital costs had given early indications of a far higher capital cost for the refurbishment of the retained estate than the capital costs required for a new office block. Mr Calderwood explained the funding arrangements to support a circa £20m capital investment in a new build and a site had been identified close to the Teaching and Learning Centre which could accommodate the office block.

Mr Lee enquired about the existing office accommodation if the decision was to proceed with the new build option. Mr Seaborne advised that the intention would be to demolish the buildings, some of which dated back to the 1870s and others were of a prefabricated nature dating from the 1960/70s. Consideration would be given to the position with regard to any buildings listed within that area.

The Committee were being asked to approve the submission of the initial agreement document to the Capital Investment Group for consideration at their meeting on 13 August 2013 and also to approve the development of an outline business case for the new office block.

Dr Armstrong and Ms Grant then highlighted Appendix B which was a paper on haematology and haemato-oncology at the new Southside Hospital. Currently there were 52 designated haematology inpatient beds across NHSGGC – 38 at the Beatson West of Scotland Cancer Centre (BOC) and 14 at the Southern General Hospital (SGH). Currently there was an issue of sustaining the Bone Marrow Transplant Unit (BMT) at the Beatson as new standards indicated that the Unit should be collocated with an Intensive Care Unit. In addition, there were ongoing discussions with the haematologists as part of the Clinical Services Review to look at the clinical model for this service across NHSGG&C. There has been discussion regarding the need to develop non acute and acute services for this speciality.

It was proposed that the Bone Marrow Transplant Unit at the BOC together with the haemato-oncology beds at the SGH transfer to the new Southside Hospital in 2015. In addition, the haemato oncology team will conclude the debate concerning acute and non acute haematology. The capital cost would be £840,000 with no revenue cost implications. There was an opportunity at this stage to introduce this change to the contract at the new Southside Glasgow Hospital without disrupting the ongoing work and would be funded as a client instructed change for the new hospital. The clinical case was strong, with clinical support provided to the Medical Director for the relocation of the BMT Unit and in relation to the vacated beds at the Beatson West of Scotland Cancer Centre, Mr Calderwood advised that

with the annual increases affecting cancer services, it was likely that the freed up capacity would be utilised going forward.

Mr Winter, who was the Non-Executive member involved with the new Southside Hospitals contract, took the opportunity to pay tribute to Mr Alan Seaborne for managing so effectively and professionally the £842m publically-funded new Southside Hospitals and Laboratory project. Mr Seaborne was attending his last meeting prior to his retirement at the end of the month. Mr Winter wished it recorded that the Committee acknowledged the significant contribution he had made to managing all aspects of this huge contract. The contract remained within budget and on time, and many additional benefits had been realised during the length of the contract. The Committee endorsed these views and thanked Mr Seaborne and wished him well for a long and happy retirement.

DECIDED

1. That the progress of Stage 2 (design development of the new hospitals) and Stage 3 (construction of the adult and children's hospitals) be noted.
2. That the initial agreement document be approved for submission to the Capital Investment Group for consideration and the development of an outline business case for the new office block be agreed and submitted to a future meeting of the Committee for consideration.
3. That the changes in the Service Model for haematology and haemato-oncology be approved at a cost of £840,000 to be funded as a client instructed change and that it form part of the construction of the new Southside Hospital.

Project Director

Project Director

79. EASTWOOD HEALTH AND CARE AND MARYHILL HEALTH CENTRES OUTLINE BUSINESS CASES

There was submitted a paper [Paper No: 13/69] by the Director of Glasgow City CHP summarising the outline business cases (OBCs) for the development of a new Eastwood Health and Care Centre and a new Maryhill Health Centre. Both projects were proposed to be bundled into one contract to be provided by Hub West of Scotland as part of the Scottish Government's approach to the delivery of new community infrastructure. A copy of the full OBC had been electronically sent to members of the Committee. Ms Hawkins advised that a land ownership issue at the site identified for the Maryhill Health Centre may slow down the process however steps were being taken with the Central Legal Office to find an acceptable way forward in order to replace the existing Maryhill Health Centre as a new build at Gairbraid Avenue.

Ms J Murray, Director of East Renfrewshire CHCP, took members through the proposal for a new build Health and Care Centre at Drumby Crescent, Clarkston. The project would provide a range of health and social care services for the population of Eastwood and would provide space for five GP practices as well as 250 CHCP staff. Councillor Lafferty commented that the proposals built on the success of the recently opened Barrhead Health and Social Care Centre and had also followed an extensive public consultation exercise.

Mr Winter enquired about the continuing revenue support that would be required if the scheme was not completed by the stipulated date within 2015. Ms Hawkins advised that assurances had been given around this point by SGHD but she would

seek a more formal level of assurance to mitigate this possible risk. She was hopeful that this point would be covered by the time of the submission of the full business case to the Committee for approval.

**Director, Glasgow
CHP**

The initial capital estimate for the Eastwood Health and Care Centre was £14,675,415 and East Renfrewshire Council was an equal partner in the project with £6.13m of capital funding secured for the project. The revenue costs (unitary – capital, lifecycle and hard facilities management) would be mainly funded by the Scottish Government and the funding was set at 85% of the cost. The OBCs were subject to value for money assessment within SGHD and plans were in place to ensure that additional operating revenue costs would be met from within the existing East Renfrewshire CHCP budget.

In relation to the Maryhill Health Centre proposal, Ms E Borland, Head of Planning and Performance, Glasgow CHP, North-West Sector, advised that the current Health Centre had been built in the 1970s and was now of a poor fabric and had been identified as a priority for replacement in the National Scottish Health Department Property and Asset Management Survey. The building of the new Health Centre in Gairbraid Avenue, within an area of deprivation, was a tangible example of the NHS Board's commitment to tackling health inequalities and the building would house four GP practices and a range of community health services including community dental services and a pharmacy. The new Health Centre would also be adjacent to the Maryhill Burgh Halls and Councillor Kerr gave his support for the joint working being undertaken in developing this Health Centre and believed it would be an asset to the area of Maryhill.

The initial capital cost estimated for the new Maryhill Health Centre was £12,105,977. The revenue costs would be mainly funded by the Scottish Government and the funding was set at 85% of the cost. The Outline Business Cases were subject to value for money, assessment within SGHD and plans were in place to ensure that the additional operating revenue costs would be met within existing Glasgow CHP budgets.

Mr Winter highlighted that some time ago agreement had been reached that the summaries of outline business cases would cover a standard format and provide information on predetermined areas such as capital, revenue, site implications, services, etc. He had been disappointed that this standard format had not been covered on this occasion. Ms Hawkins agreed that she would discuss further with Mr Winter a standard format/template which would be acceptable for all future summaries of outline business cases being submitted to the Quality and Performance Committee for approval.

**Director, Glasgow
CHP**

DECIDED

1. That the outline business case for the Eastwood Health and Care Centre be approved for submission to the Scottish Government's Capital Investment Group.
2. That the outline business case for the new Maryhill Health Centre be approved for submission to the Scottish Government's Capital Investment Group.

**Director, East
Renfrewshire
CHCP**

**Director, Glasgow
CHP**

There was submitted a paper [Paper No: 13/70] enclosing the minutes of the Capital Planning and Property Group meeting of 30 April 2013.

NOTED

81. FOOD, FLUID AND NUTRITIONAL CARE UPDATE

There was submitted a paper [Paper No. 13/62] from the Nurse Director providing an annual update in relation to the implementation of the Food, Fluid and Nutrition Care across NHSGGC. Significant progress had been made in relation to compliance with national guidelines for catering standards and best practice in nutritional care within all inpatient services. Challenges remained in relation to consistency of application. Detailed monitoring was now routinely undertaken in the form of patient feedback and engagement, audits and clinical quality indicators to ensure local action plans were developed in relation to any identified shortfalls. Lessons from national improvement reports and inspections were routinely used to drive further improvements. While patient satisfaction scores were higher than in previous surveys, expectations required further improvement and new targets of 90% compliance were proposed.

Dr Benton enquired about training for volunteers and Ms Crocket advised that their primary focus was to support patients around mealtimes in the form of assisting with menu selection, decluttering bedside tables and assisting patients with washing their hands. They did not feed patients, particularly those with swallowing difficulties. This was a task for the nursing staff.

Ms Crocket advised that Speech and Language Therapy staff had been involved in the review and in terms of their availability within ward areas, they worked from Mondays to Fridays.

Mr Lee enquired about the hospitals within partnerships and Ms Crocket advised that progress was being made within mental health hospital settings and ongoing catering satisfaction monitoring of mental health services sites was included as part of the Board satisfaction survey.

NOTED

82. SERVICES TO TRANSGENDER PEOPLE

There was submitted a paper [Paper No: 13/63] by the Director of Corporate Planning and Policy setting out the progress to ensure NHSGGC had a patient pathway between the GID and regional acute services which was clinically appropriate and compliant with equalities legislation and the Board's wider public sector equality duty.

The two stage review process was underway with the Medical Director bringing together the appropriate GID and regional services clinical teams to review the current clinical pathway for transgender patients and thereafter an equalities focussed review would be commissioned post-clinical pathway including input from transgender patients. Ms Micklem welcomed the work underway to ensure these services were appropriately delivered to this group of patients.

NOTED

83. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 30 APRIL 2013

There was submitted a paper [Paper No: 13/64] enclosing the minutes of the Quality Policy Development Group meeting of 30 April 2013.

NOTED

84. STAFF GOVERNANCE COMMITTEE – MINUTES OF MEETING HELD ON 21 MAY 2013

There was submitted the minutes of the Staff Governance Committee meeting of 21 May 2013.

NOTED

85. REVIEW OF REMIT OF QUALITY AND PERFORMANCE COMMITTEE

There was submitted a paper [Paper No. 13/65] by the Head of Board Administration asking the Committee to consider whether any changes were required to the remit and arrangements for supporting the Quality and Performance Committee. The review conducted at the July 2012 Committee meeting had concluded that a further review be held in one year's time and the two issues which had been highlighted during that year had been matters relating to clinical governance and public involvement.

There was recognition that the high level strategic operation of the Committee together with the scrutiny and challenging function was being met by the Quality and Performance Committee. However, carrying out these functions through a single committee was a challenge in terms of manageable agendas, appropriate scrutiny to all papers and issues, the length of the meeting and some members concerns that the integrated approach which was desired in setting up the Quality and Performance Committee was not being achieved.

There was a recognition that the person-centredness and patient experience responsibilities had not been adequately covered in the current remit of the committee and these responsibilities would be set out in a revised remit.

**Head of Board
Administration**

Mr James, in relation to a comment that there was no finance report at the July meeting, advised that the month 2 figures showed an overspend of £780,000 and this had been in line with the similar period last year. He was aware that there was no template to integrate finance into the range of papers considered by the Committee and that this was possibly one of the areas to be considered in trying to achieve a more integrated approach to the responsibilities of ensuring quality, patient safety, patient experience and financial planning and decision making processes. Mr Lee acknowledged this point and mentioned that the intention had been to receive a one-page summary of all papers for this meeting in order to assist members understanding of the issues to be discussed and approved. This new initiative had not been universally followed by authors of papers submitted.

Mr Sime suggested that the Committee give consideration to approving the current remit, with the addition of responsibilities for person-centredness, patient experience, and thereafter, discuss the remit and the standing committee

arrangements at the NHS Board members' away day. Members sought a range of options so that full consideration could be given to any possible alterations to the current committee arrangements. Ms Renfrew added that the integration of Health and Social Services would also have an impact on the accountability of the Board and would also result in further changes.

DECIDED

That the remit of the Quality and Performance Committee be approved subject to the addition of responsibilities for person-centredness and patient experience matters and that the remit and Committee arrangements be discussed at the next NHS Board members' away day.

**Head of Board
Administration**

86. DATIX SHORT LIFE WORKING GROUP

There was submitted a paper [Paper No 13/66] by the Medical Director setting out a proposal to undertake a review of Datix functionality to ensure that it was fit for purpose and able to support full compliance with the Incident Management Policy, Significant Clinical Incident Policy and other applications.

Datix was the IT system used to support the management of the incident reporting, complaints, legal claims and freedom of information processes. A number of concerns and issues about the use and functionality of Datix had recently been reported through various channels throughout the NHS Board and these concerns included IT/technical issues, wider process issues and the need to ensure that the functionality of Datix was fit for purpose going forward.

A Short Life Working Group was being formed which would report jointly to the Clinical Governance Forum and the Health and Safety Forum and thereafter, the Corporate Management Team and Audit Committee.

NOTED

87. MEDIA COVERAGE OF NHSGGC MAY/JUNE 2013

There was submitted a paper [Paper No: 13/67] by the Director of Corporate Communications highlighting outcomes of media activity for the May/June 2013 period. The report supplemented the weekly media roundup which was provided to NHS Board members every Friday afternoon and summarised media activity including factual coverage, positive coverage and negative coverage.

NOTED

88. DATE OF NEXT MEETING

9.00am on Tuesday 17 September 2013 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:55pm