

DRAFT

QPC(M)13/06
Minutes: 119 - 143

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 19 November 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	Cllr A Lafferty
Ms M Brown (To Minute 141)	Ms R Micklem (To Minute 137)
Dr H Cameron	Cllr J McIlwee
Mr P Daniels OBE (From Minute 123 to 134)	Mr D Sime (To Minute 141)
Mr I Fraser (To Minute 141)	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 P James
Mr R Calderwood	Mr A O Robertson OBE (To Minute 137)
Mr R Finnie	Rev Dr N Shanks (To Minute 141)

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

Mr G Archibald	..	Director of Surgery and Anaesthetics
Ms L De Caestecker	..	Director of Public Health
Mr A Crawford	..	Head of Clinical Governance (For Minute 130)
Mr A Finlayson	..	Head of IT Infrastructure
Mr A Gallacher	..	Technical Manager
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Ms M A Kane	..	Director of Facilities
Ms L Kelly	..	Head of Policy
Mr D Loudon	..	Project Director - South Glasgow Hospitals Development (For Minute 141)
Ms F McNeill	..	General Manager, Specialist Mental Health Services (For Minute 132)
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting
Mr I Reid	..	Director of Human Resources (To Minute 141)
Mr D Ross	..	Director, Currie & Brown UK Limited (For Minute 141)
Ms H Russell	..	Audit Scotland (To Minute 140)

119. APOLOGY

An apology for absence was intimated on behalf of Mr B Williamson.

120. DECLARATIONS OF INTEREST

There were no declarations of interest raised.

121. 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 17 September 2013 [QPC(M)13/05] were approved as a correct record.

122. MATTERS ARISING

- (a) Rolling Action List

NOTED

123. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No: 13/97] by the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGGC's performance. Of the 45 measures which had been assigned a performance status based on their variation from trajectory and/or targets, 28 were assessed as green; 9 as amber (performance within 5% of trajectory) and 8 as red (performance 5% outwith meeting trajectory).

The key performance status changes since the last report to the Committee included:-

- Overtime usage had moved from red to amber;
- Smoking cessation had moved from amber to green;
- Antenatal care had moved from red to green;
- Suspicion of cancer referrals had moved from green to amber.

Members had raised concerns at the last meeting about waiting times for access to physiotherapy. A new national target of four weeks was to be set for 2014/15 however, at the members' request, this and future papers would cover the actions being taken to prepare to respond and adhere to this target in the future. The HEAT target would be to reduce musculoskeletal waiting times, although a detailed target definition was still to be agreed. The average wait time was currently nine weeks and in response to Dr Cameron, Ms Mullen advised members that the range of waiting times covered 3-19 weeks. Data collection systems were still being put in place in preparation for the target however, there would be a focus on those areas with the highest wait times and future reporting to the Committee would include variations from the trajectory and also include the range of wait times across NHSGGC.

Mr Finnie enquired about the performance information in relation to the suspicion of cancer referrals (62 days) and was advised that the current performance was at a given moment in time and was currently a four week wait. The NHS Board had invested up to £30m in this area.

Ms Brown enquired about the performance status/in progress against the early diagnosis and treatment in first-stage cancer. Mr Archibald advised that Acute Services were working on a theme basis to improve performance and he would submit a paper to the next meeting of the Committee describing the work underway together with the next steps in reporting performance to the Committee. Overall the performance in recent years had been acceptable although there had been a

**Lead Director,
Acute Services**

recent dip which affected a few lung cancer patients. The actual target was still to be confirmed by the SGHD and information was being collected in order to determine a start point, which would then be used thereafter to measure performance. Some cancers were not staged and there could be a long lead-in time causing difficulties with monitoring in real time.

Ms Hawkins advised that there had been some difficulties in the provision of training for suicide prevention as had been reported at the last meeting.

Ms Mullen agreed that future reports would retain the measures which had not been updated since the last meeting in order to give members a full picture of performance against all measurable targets.

**Acting Head of
Performance &
Corporate
Reporting**

NOTED

124. SCOTTISH PATIENT SAFETY PROGRAMME: UPDATE

There was submitted a paper [Paper No: 13/98] setting out the progress against the Scottish Patient Safety Programme (SPSP). In particular the work being undertaken within primary care in relation to medicines reconciliation; disease modifying anti-rheumatic drugs; heart failure; prevention of pressure ulcers in the community; and insulin administration in the community. In addition it had been agreed that all GP practices in Scotland be invited to participate in SPSP activity; this would take the form of 11 QOF points to look at the safety climate survey within clinical teams and using the trigger tool to identify previously undetected evidence of patient safety incidents and identify learning from them.

Dr Armstrong also drew members' attention to the Chief Executive's Letter in relation to governing the Acute Adult Care Programme and reported on the progress in relation to the three areas of focussed work – patient safety essentials; points of care and infrastructure/leadership. In particular she advised that the extended scope of the programme requirements for improving the deteriorating patient was recognised to be a significant challenge. Therefore a small planning group was being convened to describe the fuller programme plan and an overarching programme design paper was to be submitted for approval by the Acute Services Clinical Governance Forum.

The report highlighted that the hospital standardised mortality ratio (HSMR) had indicated that the rate for Inverclyde Hospital had fallen from 1.08 in the last quarter of the last year to 0.82 for the first quarter of 2013/14. The plan however, was to continue with the improvement programme at Inverclyde as the trend of HSMR had demonstrated considerable variability from the baseline in 2007 and its improvement rate was not as rapid as other hospitals within NHSGGC.

In relation to the Healthcare Improvement Scotland visit to the NHS Board on 3 September 2013, Ms Micklem asked about the funding difficulties highlighted in releasing staff for training. Dr Armstrong advised that NHS 24 had previously assisted in this area and had changed their practice nationally in the recent past. Discussions were ongoing to see if it would be possible to reinstate the previous arrangements where calls to GPs were taken by NHS 24 to allow staff to be freed for training purposes.

In relation to Ms Micklem's point about identifying outcome measures for improvement activity, Dr Armstrong advised that this was work in progress as they sought a reliable indicator i.e. expected rate of readmission. She also advised of the

work underway to ensure that medical staff highlighted to GPs in the discharge letter why particular drugs had been stopped within hospitals.

NOTED

125. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No:13/99] by the Medical Director providing an exception report on the NHS Board performance against HEAT and other HAI targets. Current analysis of staphylococcus aureus bacteraemia infection (SAB) indicated an upward trajectory in the quarter April-June 2013. The revised March 2015 HEAT target was 24 SAB cases per 100,000 Acute Occupied Bed Days (AOBDs) and currently NHSGGC demonstrated a rate of 27.4 (which was still below the national average of 29.5). Dr Armstrong reported that this was mainly due to patients being admitted with infections from the community. A whole-system review was underway and also contact was being made with Birmingham which had achieved a 0% rate of SABs within their hospitals. Weekly reporting was now underway in order to try and manage an improvement in the current rate.

Dr Armstrong also highlighted the incidence of C-Difficile within Ward 15 at the Vale of Leven Hospital. There had been three cases in October 2013 in Ward 15 and the ward was closed to admissions and transfers following the identification of two C-Difficile cases. The ward was reopened to admissions on 4 November and there have been no reported new cases identified since 28 October. Overall the HEAT target was 25 C-Difficile cases or less per 100,000 AOBDs for all patients and NHSGGC demonstrated a rate of 33.5 (which is below the national average of 33.6). Mr Sime thanked Dr Armstrong for highlighting this particular matter and he felt that staff had reacted well and that the introduction of process charts had clearly been very helpful.

NOTED

126. CLINICAL RISK MANAGEMENT REPORT: SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS AND FAIs

There was submitted a paper [Paper No: 13/100] by the Medical Director on the handling of adverse clinical incidents together with an update on the current fatal accident enquiries. The full 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.

In relation to the development of the NHS Board's Significant Clinical Incident Policy, it was reported that discussions were still ongoing with Healthcare Improvement Scotland around a few issues including changes proposed nationally to the Severity Rating Matrix and consideration of what the implications may be for NHSGGC continuing to use its existing categories which had the benefit of the possibility of learning to be gained where systems should have been expected to prevent the event along with a review of near misses. Once the national guidance has been published, the NHS Board's Significant Clinical Incident Policy would be submitted, hopefully in January 2014, to the Committee for approval and thereafter implemented.

Dr Armstrong highlighted to members the detailed directorate-by-directorate information which was included in the report for the first time in relation to

significant clinical incidents. She was open to suggestions about the inclusion of this type of information or further detail in future reports and the general view from members had been that this was helpful and brought a useful perspective to the information presented in this report. Dr Armstrong then provided an update on the current and ongoing fatal accident enquiries and presented a case study to members and highlighted areas where improvements had been made as a result of that particular case. In responding to a range of members' questions, it was agreed that a paper would be submitted to a future meeting of the Committee on the use of pagers within hospitals, with the particular emphasis on any areas where pagers did not operate effectively.

**Director of
Facilities**

NOTED

127. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 21 OCTOBER 2013

There was submitted a paper [Paper No: 13/101] in relation to the Board Clinical Governance Forum meeting held on 21 October 2013.

NOTED

128. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 JULY-30 SEPTEMBER 2013

There was submitted a paper [Paper No:13/102] by the Nurse Director setting out the handling of recommendations made by the Scottish Public Services Ombudsman (SPSO) in their published reports and decision letters relating to NHSGGC for the period June to September 2013. There had been no investigative reports however 18 decision letters had been received and eight of these related to acute services, four to partnerships, five to GPs and one to a dental practice. The Ombudsman had investigated a total of 25 issues; seven of which had been upheld and 18 not upheld. The Ombudsman had made 14 recommendations.

The report had also included a summary of the National Education for Scotland Masterclass Event which had been held on 25 October 2013 and attended by three Non-Executive Directors – Mr Lee, Ms Micklem and Mr Finnie together with Ms Crocket, Nurse Director and Mr P Cannon, Head of Administration (Acute Services). Members had found the Masterclass Event particularly helpful in hearing the perspectives from the Ombudsman and the recent experiences of improving complaints handling by Glasgow Housing Association. Mr Calderwood advised that he had asked Ms Crocket to consider whether the current structure for handling complaints hindered or benefitted the intentions of bringing about further improvement to the quality of local resolution and responses and the moves to adopt a less defensive approach to those complaints raised with NHSGGC. This would form part of the discussions on the NHS Board structures at the February away sessions with NHS Board members. Ms Hawkins advised members of the changes to the handling of complaints for prisoners accessing health services and the impact these changes have had on the number of complaints received. Currently the process required attempts to resolve a prisoner's concerns within three working days.

Nurse Director

Ms Micklem emphasised how beneficial she felt the Masterclass Event had been, particularly around the scrutiny role and how far the NHS Board should be required to look for reassurance and how far to challenge the information presented and

officers in order to be satisfied that the system was working adequately for patients. Mr Finnie added that he felt that the presentations from the Ombudsman and Glasgow Housing Association had highlighted the significance of the culture of the organisation and how a move away from a less defensive approach led to better outcomes and greater patient satisfaction.

NOTED

129. ANALYSIS OF LEGAL CLAIMS – MONITORING REPORT (MID-YEAR REVIEW 2013)

There was submitted a paper [Paper No:13/103] from the Head of Board Administration providing an overview of the handling and settlement of legal claims within NHSGGC as at September 2012 to September 2013. Background information was also provided in relation to the role of the Central Legal Office and the Clinical Negligence and Other Risks Scheme (CNORIS).

In overall terms the number of cases settled was lower than the previous year however, the amounts awarded continued to grow. The financial information provided within the report required further refinement in future reports to capture the impact of the periodic payment orders which committed the NHS Board to annual expenditure over the lifetime of the patient receiving compensation.

Mr Finnie enquired about the consultations with the Legal Office in determining whether to defend cases or seek early settlement to reduce exposure to costs. Mr Calderwood advised that an assessment was made of individual cases and where negligence on the Board's part has been clearly proven, negotiations would be undertaken with the other party in order to try and settle the claim at an agreed sum with no requirement to go to court. There were however, occasions when legal advice had suggested a robust defence of a case was possible, however, very occasionally that position changed just at the point of the court hearing and updated advice from the Legal Office had recommended settlement. Mr Calderwood provided an example to illustrate that point.

Mr Lee invited Ms Mary Anne Kane, Director of Facilities to update members on the recent media coverage on asbestos claims against NHSGGC. Ms Kane advised that following a number of Freedom of Information requests about health and safety referrals and meetings in relation to asbestos within hospitals, the media had published an article which did not portray the full position within NHSGGC. She advised that a legal action regarding asbestos in the plant room at the Southern General Hospital site was underway, however, the NHS Board had been advised by the Health and Safety Executive that no action would be taken against the Board following their investigation into asbestos at three other sites – Clydebank Health Centre, Dykebar Hospital and the Skylark Centre and Inverclyde Royal Hospital. Ms Kane also reported that the NHS Board had now employed a highly qualified and dedicated member of staff in relation to asbestos in order to identify current and future issues so they could be tackled in an ongoing way. Members welcomed this update and information.

NOTED

130. PERSON-CENTRED HEALTH AND CARE COLLABORATIVE, STRATEGIC WORK PLAN AND REPORT

There was submitted a paper [Paper No:13/104] from the Nurse Director setting out the work undertaken within NHSGGC to the National Person-Centred Health and Care Collaborative, describing the progress made locally with the pilot improvement teams in clinical services within the Board. Mr A Crawford, Head of Clinical Governance presented the report and highlighted three main areas:- themed conversations with patients; coproduction and the case study involving the Community Respiratory Team in the North West Community Health Partnership.

Ms Micklem indicated that she had found the report very helpful and would be keen that the Committee received regular updates on this initiative. She was particularly keen on the development of the key engagement principles for inequalities sensitive practice which had been targeted for completion by December 2013. It was important to hear everyone's voice and she would be keen to see the outcome of this piece of work. In relation to coproduction, there was acknowledgement that this meant different things to different people and it would be useful to have a specific definition. It was agreed that it would be best to set aside some time at a future NHS Board Seminar to explore this area further.

**Head of Board
Administration**

Ms Brown enquired as to how all the issues could be brought together in order to see the bigger picture and see what improvements were being made in which areas. Mr Crawford indicated that this was a significant challenge in terms of the work of clinical governance, performance management, team-based approaches and a local and Board focus. To bring this all together into something like a balanced scorecard at this very early stage of development would be challenging. Ms Brown still felt it important that the NHS Board should have access to the overall benefits or otherwise of the various initiatives and programmes underway. Mr Sime acknowledged that a lot of this type of work still operated within sites and was not brought to the NHS Board in a way where you could see the bigger picture and overall improvements.

Dr Armstrong agreed that it was important to attempt this with the information available in order that members had an insight into what was happening in different hospitals and different services driven by a whole range of information streams and clinical indicators. A further Board discussion, possibly at the February Away Sessions, would be necessary and Mr Calderwood emphasised the need to bring patient experiences and desires together as part of the type of information NHS Board members would expect to see to allow them to take investment decisions in particular services. It was important to recognise that the bringing together of all of that information and intelligence could be hugely beneficial in understanding the areas that required further concentration and greater effort.

NOTED

131. PLANNING FOR THE COMMONWEALTH GAMES - 2014

There was submitted a paper [Paper No: 13/105] from the Director of Public Health providing members with an update on the planning taking place by NHSGGC in terms of its preparedness for the Glasgow 2014 Commonwealth Games which would take place between 23 July and 3 August 2014. It would operate in three site clusters – East End, West End and South Side and the Games Athletes' Village

would be in the East End of Glasgow. It was expected that there would be 4,500 athletes competing over eleven days and 1.4m spectators expected to attend the events.

NHSGGC Civil Contingencies Planning Unit had been working with partners including the Commonwealth Games Organising Committee (medical services, transport services, food safety, safety and security); Scottish Government NHS Resilience Team, the Police, Ambulance Service, Local Authorities and Health Protection Scotland. 14 clinical expert groups had been formed to assist the Organising Committee Medical Services in the planning of medical provision and 11 Task and Finish Groups had been formed to lead the planning at NHS Scotland level through the NHS Resilience Team.

Glasgow Royal Infirmary was to be the designated hospital for athletes during the Games and one of the major challenges would be the issue of the availability of key staff. Some would be volunteering, some providing a health role to the Games or spectating at the events. Discussions had been undertaken with staff to ensure adequate services at the hospital were in place to meet demand and that the business continuity planning was robust and able to deal with higher than normal demand from athletes, their families and visitors to the city.

Mr Daniels was pleased to read that the Memorandum of Understanding had now been agreed and that the Organising Committee was responsible for providing medical services and this helped to clarify the NHS Board's role.

In addition, Festival 2014 were in the process of planning live events for the Games at Glasgow Green, Merchant City and Kelvingrove, and these were not part of the responsibility of the Organising Committee and would be run by private providers. It was possible that these events could have a knock-on effect on attendances at Accident and Emergency departments.

Members welcomed the update and asked that a further report be submitted to the March meeting of the Committee in order to be kept abreast of developments in this important area.

**Director of
Public Health**

NOTED

132. PSYCHOLOGICAL THERAPIES – HEAT TARGET

There was submitted a paper [Paper No: 13/106] from the Director of Glasgow City CHP providing, at members' request, a detailed report of the actions being undertaken by the teams/services across NHSGGC to deliver the psychological therapy HEAT target of 18 weeks waiting time from December 2014. The psychological therapy HEAT target was to specifically report on the delivery of psychological therapy treatments for mental illness or disorders. These can be delivered by health and/or care staff of any profession; not necessarily a psychologist, who are trained to deliver a particular intervention and who have the appropriate supervision arrangements in place. The 18 week target applies across the whole pathway from referral to treatment.

Ms Hawkins took the members through the detail of the paper and introduced Ms Fiona McNeill, General Manager, Specialist Mental Health Services, to assist with answering members' questions.

Over 100 teams/services that provided psychological therapy treatments for mental

illness and disorders had been identified, and this covered community and in-patient services, including the Rehabilitation and Assessment Directorate. As at the end of September 2013, NHSGGC were reporting activity of 98 of these teams/services.

During September 2013, 914 people commenced psychological therapy treatment of which 85.3% commenced their treatment within 18 weeks, with a median wait of six weeks. The current position for those still waiting for a psychological therapy treatment was that at 30 September 2013, 2,338 people were still awaiting their psychological therapy treatment to commence. 82.5% of those waiting were within the 18 week target and the median wait of all those waiting was nine weeks. Of those waiting, they were distributed across 46 teams/services and these teams had provided an update on the actions they were undertaking to ensure that arrangements would be in place to meet the waiting time target of 18 weeks by December 2014.

Rev Shanks welcomed the comprehensive nature of this report and noted the different arrangements and investment down South. He was concerned about the exceptionally high waits, 36 weeks within the Glasgow North West Sector. Ms McNeill indicated that there were a few exceptionally long waits and whilst these were being tackled, Ms McNeill explained that these cases tended to be exceptional outliers and tended not to be indicative of the usual pattern of waits. It would be important going forward, to ensure the understanding of what exactly the psychological therapy HEAT target covered in reporting terms and what it did not. Ms McNeill explained that whilst some psychological interventions such as counselling and higher volume low-intensity interventions (e.g. stress control classes) were not included within the monthly reports, there was evidence that a substantial proportion of people with mild/moderate mental illness and disorders could be treated effectively with these interventions, thus reducing the demand for more specialist therapy types. Members welcomed the detail provided in the report and would monitor the progress via the updates given in the Integrated Quality and Performance Report submitted to future meetings.

NOTED

133. REDESIGN OF GP OUT-OF-HOURS SERVICES

There was submitted a paper [Paper No: 13/107] by the Lead Director, Acute Services Division setting out the arrangements for the GP Out of Hours Services (OOH) across NHSGGC. Previous discussions had highlighted that the filling of OOH shifts had become increasingly problematic over recent months and as recently as summer 2013 NHSGGC had to offer similar rates of pay to that of a neighbouring Health Board to ensure that all shifts could be filled. Ongoing discussions had been held at a national level and from September 2013 a 5% uplift was applied in NHSGGC to the sessional rate, recognising that GPs had not had a pay rise for this work since 2004/5. This increase had stabilised the weekend service throughout September/October and the service had continued to fill all shifts at all times although this had been administratively time consuming as staff had to telephone GPs during the week to encourage them to take up remaining shifts within a rota.

In relation to filling shifts during the festive season, these shifts were advertised some six months in advance and doctors indicated their availability for those shifts. Enhanced rates had been paid over the festive period since the inception of the OOH service, however, three weekends over the festive period were still vacant,

this being significantly higher than in previous years. These weekends being 21/22 December; 28/29 December and 4/5 January 2014. All GPs within NHSGGC had been contacted to ask them to participate and the Partnership Clinical Directors and Local Medical Committee had also been asked to encourage GPs to take part in these shifts. A range of other options had been considered including reviewing those primary care emergency centres with the least activity to see if services could be brought together at a different location. As this would require additional patient travel at this time of the year together with the need for additional staff being required at the remaining centres and therefore would not reduce the need for GPs to cover shifts, this option was not pursued further. It was therefore recommended that the sessional rate be increased on the three weekends in question with an overall additional cost to the NHS Board of £80,000.

In addition, the Director of Human Resources would lead a group reviewing the employment position of GPs who work both as independent contractors and for the NHS Board. In addition, as part of service planning, the location and number of primary care emergency centres required was now under review and options for change would be generated which could then be subject to formal public consultation as required.

Councillor McIlwee intimated that he understood the difficulties but would not support any move of activity from the Inverclyde/Greenock and Lomond areas to Paisley.

Mr Finnie wondered if it was possible to draw conclusions from the table showing October 2013 against December 2012 activity and overlay the OOH calls with contacts to NHS 24 and Accident and Emergency attendances. Mr Calderwood indicated that that would need to relate to Accident and Emergency departments after midnight and the attendances at that point dropped. Clearly it would be a different profile than that shown within the table although it had been recognised that the vast majority of calls to NHS 24 led to a GP OOH visit or attendance at an Accident and Emergency Hospital.

DECIDED

- That the additional rate of pay for the weekends of 21/22 December 2013, 28/29 December 2013 and 4/5 January 2014 be agreed and that the ongoing work to redesign the OOH service be noted.

**Lead Director,
Acute Services**

134. POST-INCIDENT REPORT ON RECENT ICT SYSTEMS FAILURE

There was submitted a paper [Paper No: 13/108] by the Director of Health Information and Technology asking members to note the findings of the post-incident review into the recent ICT systems disruption.

Following the incident which resulted in the failure of a significant number of ICT systems within NHSGGC during 1-2 October 2013, the Board and the Scottish Government jointly commissioned an independent review of:-

- The technical environment which was in place when the failure occurred;
- The response to the incident by ICT staff and services.

The review followed a commitment made by the Cabinet Secretary for Health and Wellbeing to ascertain the root cause of the problem and ensure that the lessons learned in NHSGGC were available to be shared with other Boards. The aim was

to enable them to assess their preparedness to recover from similar incidents in future.

Mr Alasdair Finlayson, Head of IT Infrastructure, presented the paper and findings and recommendations of the review team and highlighted that while the technical environment was assessed to be in accordance with industry standard best practice, the review team set out a number of areas that would provide additional security to the Board in the event of similar service failure in future. These were set out as recommendations within the report.

A second phase of review and assessment would be conducted by the National Computing Centre on behalf of the Scottish Government and would concentrate on the resilience shown in NHS GGC and assess whether further improvements were necessary in contingency planning and whether other Boards were equipped to operate to a similar level in the event of failure. In response to a question from Mr Sime, Mr Finlayson advised that Microsoft had cooperated with the review however, the root cause had not been determined.

Councillor Lafferty acknowledged that this event had been unprecedented and had wondered whether there was any human intervention element which could be detected. Mr Finlayson and Mr Calderwood replied that whilst this was the first time such a failure had ever occurred, the investigations undertaken to date had not identified any breach in the IT systems and Microsoft had not identified or found any external source for the problem.

Mr Finnie wondered what the risk was if this was now to be added to the Risk Register. Mr Calderwood intimated that increased resilience and more interrogation/screening was being introduced to the whole system to ensure that checks were regularly undertaken on an hourly basis. The firewall had not been hacked and no evidence had been found thus far of human intervention.

Dr Benton asked about the costs and Mr Finlayson advised that the premier contract with Microsoft was £45,000 per annum for contract support and auditing and the event itself had some increased staffing costs related to overtime during the time the IT team had tried to resolve the issue which had caused the systems disruption.

NOTED

135. WEST OF SCOTLAND RESEARCH AND ETHICS SERVICE ANNUAL REPORT 2012-13

There was submitted a paper [Paper No: 13/109] by the Medical Director in which the Annual Report of the West of Scotland Research and Ethics Service 2012-13 was enclosed for information.

NOTED

136. MEDIA COVERAGE OF NHS GGC: SEPTEMBER – OCTOBER 2013

There was submitted a paper [Paper No: 13/110] by the Director of Corporate Communications highlighting outcomes of media activity for the period September - October 2013. 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

137. CARBON MANAGEMENT REPORT

There was submitted a paper [Paper No:13/111] by the Director of Facilities setting out the NHS Board's Carbon Management Plan and the need to report nationally on emissions levels based on actual consumption as part of the Energy Efficiency Scheme.

NHSGGC as at March 2013 had failed to achieve both the energy and carbon targets associated with the HEAT targets (fossil fuel) as follows:-

- Energy target 2.97% - NHS achieved 1.87%;
- Carbon target 8.73% - NHS achieved +3.45%.

The single biggest issue impacting on the HEAT target was the NHS Board's reliance on fossil fuels whereas the Carbon Management Plan took a broader view of the carbon footprint of the organisation.

Between 2009 and 2013, 91 individual carbon reduction projects were delivered and on an annual basis the NHS Board identified a list of projects to address its carbon footprint as part of its Carbon Plan. The Appendix to the paper listed the completed projects with details of the CO² and financial savings and the projects which SGHD funding had supported during 2013/14. In addition the NHS Board had allocated £500,000 to take forward the plan of projects in an effort to reduce its carbon footprint.

The Sustainability Policy Implementation Group received written and verbal reports against the energy and carbon targets in order to monitor progress. It was recognised that in order to keep moving at the pace of the European and United Kingdom changes to regulation targets in this area, the NHS Board needed to ensure it continued to invest in and focus on reducing its carbon and energy profile as a key business objective. The NHS Board's Carbon Plan described the challenges the Board faced, which were complicated by double running and more energy-consuming technology being introduced to its sites.

Ms Kane introduced Mr Alan Gallacher, Technical Manager, who explained some of the work undertaken to identify inefficiencies within Glasgow Royal Infirmary and, in particular, the boiler house.

Mr Winter welcomed this report and asked what the typical payback time would be for investment into energy reducing schemes. Ms Kane advised that normally, it would be a 5-7 year payback although occasionally some schemes stretched as far as ten years.

Mr Finnie found the report very helpful in fleshing out the concerns he had raised at the previous Committee meeting when it had been highlighted that the Board had not achieved the HEAT targets in this area. He welcomed the steps made to improve the Board's position in this matter and could see the significant strides taken since the introduction of the Carbon Management Programme from 2009 onwards.

NOTED

138. OVERTIME AND BANK STAFF USAGE ACROSS NHSGGC

There was submitted a paper [Paper No:13/1112] by the Director of Human Resources setting out the use of overtime and bank staff in recent months. Concerns had been raised at a previous Committee meeting about the increasing use of overtime and bank staff and further details were requested by the Committee on the Board's use of both.

Mr Reid advised that the NHS Board operated a variety of banks covering various professions, the largest of which was the nurse bank. There were 9,981 individuals on the bank and of this number, 6,847 held a permanent contract with the Board i.e. 68.6% were current NHSGGC employees. In relation to overtime, this related to employees who worked more than the standard working week of 37.5 hours or more than their part time commitment.

The use of additional hours from bank staff of overtime was required to cover unforeseen staff absences caused by employee sickness, injury or accident; domestic emergencies/carer leave; maternity/paternity leave, special leave, parental leave, annual leave, study leave; coping with peaks in clinical activity and increases in admissions/A&E attendances and covering gaps in service provision caused by posts becoming vacant. In the last year, the use of bank, overtime and excess hours had averaged 5.4% of the total contracted hours. It was recognised that additional hours did fluctuate on a month to month basis although it was fairly consistent as a percentage of the total hours available. As the number of staff in post has increased, arrangements to cover have also increased in a fairly consistent manner. Monitoring was undertaken by management teams and the costs were contained within allocated budgets. The Staff Governance Committee monitors this area and Mr Sime endorsed this report and welcomed the detail contained therein.

NOTED

139. FINANCIAL MONITORING REPORT FOR THE SIX MONTH PERIOD TO 30 SEPTEMBER 2013

There was submitted a paper [Paper No: 13/113] by the Director of Finance setting out the financial monitoring report for the six month period to 30 September 2013. The NHS Board was reporting an expenditure outturn of £2.8m under budget. As part of the agreement with SGHD and to be consistent with public sector accounting rules, to fund the transitional costs of the move to the New Southside Hospital in 2014/15, it was anticipated that a year-end surplus of circa £8m would be required to be carried forward to 2014/15. This funding being clearly identified for the commissioning and double running costs of moving from existing sites to the New Southside Hospital.

Mr Winter asked about the differences in the figures indicated in this and previous reports for the NHS Board's Financial Allocation as well as a significant increase in Other income. Mr James indicated that allocations from SGHD were received monthly, however, he would in future provide a full summary of the additional allocations received and the equivalent expenditure line. As a separate note, he would write to Committee members with the explanation for the increase shown against Other income as contained within the financial monitoring report.

**Director of
Finance**

Mr Finnie indicated that the report did not seem to highlight any significant

financial pressures although he was aware of the pressure that the services were generally under. Mr James indicated that he had highlighted where particular pressures were appearing particularly within Acute Services with overspends in medical and nursing pay which to date had been offset by underspends within Partnerships. On prescribing issues, the UK arrangement recently announced with the pharmaceutical industry would be covered in the next report to the Committee. In relation to prescribing costs and the need to find additional savings from other elements of the budgets, this would be covered in greater detail in future reports, highlighting the additional savings required and where it was felt these could be achieved.

**Director of
Finance**

NOTED

140. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 28 AUGUST 2013

There was submitted a paper [Paper No: 13/114] enclosing the minutes of the Quality Policy Development Group meeting of 28 August 2013.

NOTED

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

There was submitted a paper [Paper No:13/115] by the Project Director – 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 addition, the paper included progress updates on the proposed Teaching and Learning Centre and the new accommodation (office) building.

In relation to Stage 2, the project team had continued to review the updated equipment list which had been derived from the 1:50 layouts. The Group 5 equipment procurement process had been concluded and the outcome of the tender process had been received by the project team.

Due to the proximity of the piling works to the neurosciences building and local residences, the project team had visited the site to assess the levels of dust and noise pollution which may be created. Planning permission had been received with construction work due to commence this week; the Community Engagement Team would advise neighbours of the intended works and related timescales.

In relation to Stage 3, as at 3 November 2013, 136 weeks of the 205 week contract had been completed and the project remained within timescale and budget. Contract completion remained at 28 February 2015 and Mr Loudon had provided members with images highlighting the progress of both hospitals. The construction of the multi-storey car park was currently behind schedule, however, the main contractors were in dialogue with their sub-contractors to identify areas within the programme which could be re-sequenced or accelerated. It was however, still reported that the car park would be completed by April 2014, as programmed.

The project team had identified draft proposals to provide replacement surface car parking and these proposals were being tested and priced for consideration by the Acute Services Strategy Board in the new year. In relation to the Teaching and

Learning Centre, the Full Business Case was submitted to the Scottish Government Capital Investment Group for approval on 6 November 2013 and the project will progress to construction phase during the course of this week.

The Outline Business Case for the new accommodation (office) building had been approved in September and by the Scottish Government Capital Investment Group in November. The Full Business Case would be submitted for approval to the December 2013 NHS Board and the recommendations on the proposed funding stream for the capital expenditure were set out in an Appendix to the paper.

Members welcomed the update and the new presentation of information in relation to the compensation events. Mr Lee however, was keen to meet with Mr Loudon to discuss an element of the presentation of this information in future reports.

Convenor

Mr Calderwood advised that on the fifth floor of the Teaching and Learning Centre, the University would be developing a clinical research facility as part of their capital funding and the NHS Board's contribution through revenue funding would be as part of the Board's current allocation in the field of clinical research.

Mr Loudon gave a full presentation on the progress made with the construction of both the adult and children's hospital and members welcomed this informative and detailed presentation. It was agreed that Mr Mark McAllister, Community Engagement Manager, would give a presentation to the NHS Board meeting in December on the community benefits programme.

**Community
Engagement
Manager**

NOTED

142. CAPITAL PLANNING AND PROPERTY COMMITTEE GROUP MINUTES – MEETING HELD ON 27 JUNE 2013

There was submitted a paper [Paper No: 13/116] enclosing the minutes of the Capital Planning and Property Group meeting of 27 June 2013. Mr James agreed to submit the draft minutes of this group to future meetings of this Committee.

**Director of
Finance**

NOTED

143. DATE OF NEXT MEETING

9.00am on Tuesday 21 January 2014 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 13:05pm