

**DRAFT**

QPC(M)14/01  
Minutes: 01 - 27

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the  
Quality and Performance Committee at 9.00 am  
on Tuesday, 21 January 2014 in the  
Board Room, J B Russell House  
Gartnavel Royal Hospital, 1055 Great Western Road,  
Glasgow, G12 0XH**

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**P R E S E N T**

Mr I Lee (Convener)

Dr C Benton MBE	Cllr A Lafferty
Ms M Brown	Ms R Micklem
Dr H Cameron	Cllr J McIlwee (To Minute 24)
Cllr M Cunning	Mr D Sime
Mr I Fraser	Mr B Williamson

**O T H E R B O A R D M E M B E R S I N A T T E N D A N C E**

Dr J Armstrong (To Minute 23)	Mr R Finnie (To Minute 23 and for Minute 27)
Mr R Calderwood	Mr P James
Ms R Crocket MBE (To Minute 24)	Mr A O Robertson OBE
Rev Dr N Shanks (To Minute 23)	

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

Mr G Archibald	..	Director of Surgery and Anaesthetics
Mr A Curran	..	Head of Capital Planning (For Minute 24)
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Mr D Loudon	..	Project Director - South Glasgow Hospitals Development (For Minute 22)
Mr A McLaws	..	Director of Corporate Communications
Mr J Mitchell	..	Service Manager, Inverclyde CH(C)P (For Minute 23)
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting
Ms C Renfrew	..	Director of Corporate Planning and Performance
Mr D Ross	..	Director, Currie & Brown UK Limited (For Minute 22)
Ms H Russell	..	Audit Scotland
Ms M Speirs	..	Senior Management Accountant (For Minute 23)

**01. APOLOGIES AND WELCOME**

Apologies for absence were intimated on behalf of Mr P Daniels OBE and Mr K Winter. The Convener welcomed Councillor Malcolm Cunning to his first meeting and hoped that he enjoyed the workings of the Quality and Performance Committee.

**02. DECLARATIONS OF INTEREST**

There were no declarations of interest raised.

**03. MINUTES OF PREVIOUS MEETING**

On the motion of Councillor J McIlwee and seconded by Councillor A Lafferty, the Minutes of the Quality and Performance Committee Meeting held on 19 November 2013 [QPC(M)13/06] were approved as a correct record.

**04. MATTERS ARISING**(a) Rolling Action List(i) Minute 68(b) – EQIA – Access Policy and Minute 55 – Inequalities – Gaps and Challenges

Ms Micklem asked for the progress in relation to the above-mentioned matters which had been due to be submitted to the Committee at its January 2014 meeting. Ms Renfrew advised that the EQIA – Access Policy was still work in progress and had not been completed in time for the January meeting but would be submitted to the March meeting. In relation to the Inequalities issue, she advised that the event to discuss the issues with Directors had only been held on 20 January and therefore the write-up would be completed and submitted to the March meeting of the Committee.

**Director of  
Corporate  
Planning &  
Performance**

(ii) Minute 139 – Financial Reporting and Minute 119 – Endowment Funds

Mr James advised that he would cover the outstanding actions as part of his financial planning presentation to members at the NHS Board's Away Sessions on 13/14 February 2014. In relation to the revised arrangements for non-charitable endowment funds, he advised that the National Endowments Review had now been completed and therefore he would now arrange for a meeting to be held shortly with the Endowment Trustees to discuss the new arrangements for 2014/15.

**Director of  
Finance**

NOTED

**05. INTEGRATED QUALITY AND PERFORMANCE REPORT**

There was submitted a paper [Paper No: 14/02] 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 variations from trajectory and/or targets, 29 were assessed as green; seven as amber (performance within 5% of trajectory) and nine as red (performance 5% outwith meeting trajectory).

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

- Suicide prevention training had moved from red to green;
- Overtime usage had moved from amber to green;
- Primary care community nursing standards – hand hygiene compliance had moved from amber to green;

- Emergency bed days for patients aged 75 years + had moved from amber to green;
- MRSA/MSSA had moved from amber to red;
- Admissions to Stroke Unit had moved from green to amber;
- Complaints responded to within 20 working days had moved from green to amber.

Eight exception reports had been provided to members on the nine measures which had been assessed as red (a single exemption report had been provided on the delayed discharge over 28 days and 14 days).

NOTED

## **06. SCOTTISH PATIENT SAFETY PROGRAMME: UPDATE**

There was submitted a paper [Paper No: 14/03] setting out the progress against the Scottish Patient Safety Programme (SPSP). The SPSP Acute Adult Measurement Plan had been launched in December 2013 by Healthcare Improvement Scotland and this reiterated two new national aims of the Acute Adult Safety Programme:-

- 95% of people in Acute Adult Healthcare free from the four harms in the Scottish Patient Safety Indicator – namely cardiac arrest; catheter associated urinary tract infection; pressure ulcers and falls.
- Reduce HSMR by 20% by December 2015.

The focus on patients being free from harm across the four indicators in the Acute Adult Healthcare system indicated a progression to a formal implementation of measuring and linking this aim to the Scottish Patient Safety Indicator. The paper set out the nine local actions being considered and it was recognised that this was a significant and complex programme which, if fully achieved, would be hugely beneficial for patients.

Mr Williamson welcomed this approach and felt that, at last, efforts were being made to measure the effect of disease and he believed the implications would be seen for length of stay and quality of care.

Mr Lee asked what timescale had been planned for implementing the new measures and Dr Armstrong replied that it was important to get the plans in place in order to measure progress and the challenge lay in patients with deteriorating health and this was a complex area which tested the whole pathway of care. It was agreed however, that Dr Armstrong would provide regular updates on progress in her future reports to the Committee. Ms Micklem was keen to ensure that a balance was struck in the number of targets and measures being assessed and Dr Armstrong agreed that this was a further increase in measures and therefore data collection. However, she did indicate that this new arrangement was bringing together nursing measures and it was hoped this may lead to a rationalisation of the number of different measures. However there were still a considerable number of measures highlighted and it may be that NHSGGC would focus on high priority areas in the first instance. Ms Crocket reinforced this and highlighted the example of the benefits gained from measuring an area such as tissue viability.

**Medical Director**

NOTED

**07. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT**

There was submitted a paper [Paper No:14/04] by the Medical Director providing an exception report on the NHS Board performance against HEAT and other HAI targets.

The paper highlighted a significant rise in quarter 3 (July-September 2013) with a total of 129 SAB cases which equated to a rate of 36.8 cases per 100,000 acute occupied bed days (AOBDs). The national target was 24 cases or less by 31 March 2015.

Until March 2013, NHSGGC had been progressing well and, in most cases, was achieving the HEAT targets to reduce SABs. The March 2013 target of 26 cases per 100,000 AOBDs was narrowly missed with a rate of 26.8. The first quarter of 2014/15 had shown a rise against the updated target of 24 cases to 27.4, however the NHS Board was still below the national rate of 29.5 at that time.

Despite rigorous analysis of the data, the reasons for the increase in the July-September quarter were still unclear and analysis was ongoing both within NHSGGC and Health Protection Scotland to try and identify the possible causes. Suggestions had included the introduction of the SPSP programme to identify patients with sepsis may have increased the number of blood cultures taken, although this is unlikely to be the cause, and the possible introduction of a new type of access device for lines. Weekly monitoring was in place and the enhanced surveillance data sent to Health Protection Scotland for analysis was due by February 2014 and any recommendations made would be considered/implemented. Dr Armstrong advised that the estimated rate for the quarter October-December 2013 would be similar to that of the previous quarter although early indications were that the figure may already be coming down in January 2014. The action plan in place was shared with members and there was a focus on the insertion and maintenance of lines.

Mr Williamson acknowledged the focus on MMSA and the possibility of patients who were carriers of infection within their bloodstream. Dr Armstrong acknowledged that some people carried MRSA/MMSA, particularly nasal carriage. However bloodstream infections with both MRSA/MSSA lead to considerable morbidity and mortality especially in vulnerable sick patients. This underlined the need to gain control of healthcare acquired infection.

Ms Brown was disappointed that healthcare professionals were required to be reminded to undertake best practice in preventing healthcare acquired infections. Dr Armstrong advised that the internal auditors had highlighted that there had been some conflicting policies across the NHS Board area and this had led to some different interpretations of guidance. A recent pilot of PVC compliance at the RAH indicated that while a doctor would insert a line into a patient, it worked best thereafter when the charge nurse ensured a care plan was in place to ensure regular review of the line and questioning the doctor on a regular basis as to its continued purpose.

In response to queries raised by Dr Benton, Dr Armstrong indicated that each patient had different circumstances in terms of different patterns of illness and no one patient group was more vulnerable than another. General surgery had indeed been analysed and tracked in order to reduce the frequency and likelihood of SABs and in relation to training, the critical point was where a young doctor was finding difficulty in inserting a line and knowing when to call on help from a more senior

doctor.

Mr Lee asked about the reasons for ceasing to capture the date and time of cannula insertion and Dr Armstrong advised that no evidence had been produced that this made any specific difference. It had been identified in 2009 Health Protection Scotland as good practice but not required and it was considered that too much time was being spent on something which was not making a difference. It was more important to spend the time on the care plan approach and achieve a much higher compliance which would have greater overall benefits for the patient.

NOTED

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

There was submitted a paper [Paper No: 14/05] by the Medical Director on the handling of adverse clinical incidents together with an update on the current fatal accident enquiries.

An example was given of aggregate analysis reports being used by the Acute Services Division Directorates to explore the experience of adverse incidents with a view to identifying safety priorities or reflecting on progress in improvement aims. The example was from the Blood Transfusion Committee and its role in reviewing incidents, receiving updates on progress regarding different types of training, reviewing wastage figures and developing NHS Board policy and guidance. On this occasion, the Committee had reviewed incidents from a period in 2013 and data taken from DATIX and Q pulse in October 2013 (both software systems capturing incident reporting). This provided an opportunity to look back on the incidents; increased the visibility of incidents across the Acute Services Division, and identified the key concerns; namely incorrect storage/transportation of components; breach of administration protocol and other reactions suspected e.g. allergic, infective or immune.

Two further examples were given of the Acute Falls Governance Forum and the Healthcare Associated Thrombosis Committee. Members welcomed this information.

Dr Armstrong then provided an update on the current and ongoing fatal accident enquiries and presented a case study to members and highlighted some of the difficulties where there had been no previous history known or recorded which would have given an insight into the outcome.

NOTED

**09. SIGNIFICANT CLINICAL INCIDENT POLICY – FOR APPROVAL**

There was submitted a paper [Paper No: 14/06] by the Medical Director seeking approval of the Significant Clinical Incident Policy. The draft policy had been submitted to the Committee in the latter part of 2013. It was recognised that further revision may be required if the National Adverse Events group developed further guidance and this had created some challenges in terms of full alignment with the Framework. There were many areas of good practice which overlapped with the National Framework and NHSGGC's policy. At a recent national workshop it was clear that other NHS Boards had difficulties with certain parts of the National

Framework, specifically around decision making and categorisation of significant clinical incidents. It was felt, however, that the NHS Board needed to have an approved policy in place in order to address some of the planned improvements in the arrangements identified following the internal review undertaken last year.

Mr Robertson asked about the possible additional financial and staffing implications as highlighted in the summary of the main paper. Dr Armstrong indicated that she was hoping to deliver any changes necessary within current resources.

Ms Brown asked about the consultation process undertaken, the challenges faced in meeting the three month target in completing investigations, the possible risks in not undertaking any human resource matters forward until the completion of an investigation, and she queried the length of time records required to be held particularly in relation to children's records. Dr Armstrong indicated that the consultation had included focus groups with patient involvement and full staff engagement. There were challenges in meeting the three month timescale and she was trying to bring a focus to this area; with regard to HR processes, she indicated that the policy did allow earlier intervention where there had been an obvious serious breach of professional practice or organisational policy. She agreed to review the national guidance in relation to the retention of records, particularly records relating to children and young people, and amend the policy as necessary.

Dr Cameron asked about the confidence in the system that learning would still be available from staff recording near-misses. Dr Armstrong indicated that staff would continue to complete incidents within DATIX and this would lead to local reviews, and while this would continue to be encouraged, she was conscious that this was dependent on staff recording actual incidents and near-misses. There is a currently a short life working group with membership from the Head of Clinical Governance which would ensure that the changes to DATIX supported the Board's SCI Policy.

DECIDED

- That, the Significant Clinical Incident Policy be approved subject to the outcome of any further discussions with Healthcare Improvement Scotland and the amendments made as a result of discussion with members.

**Medical Director**

**10. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 9 DECEMBER 2013**

There was submitted a paper [Paper No: 14/07] in relation to the Board Clinical Governance Forum meeting held on 9 December 2013. Dr Armstrong confirmed that the DATIX working group had identified a range of actions to bring about improvements in the DATIX system and new software and hardware had been purchased and would be tested in mid-February 2014. Further improvements would be considered.

NOTED

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

There was submitted a paper [Paper No:14/08] by the Nurse Director setting out the

work undertaken within NHSGGC in relation to the National Person-Centred Health and Care Collaborative, describing the progress of the teams involved across the Board and the Collaborative's action plan. An illustrative case study provided a tangible example of improvements as a result of the Collaborative.

Ms Micklem indicated that this was a refreshing report which provided a bottom-up approach as opposed to the many top-down targets which the NHS Board has to deliver. She was interested in the Combined Positive Experience table as shown in the quantitative summary of feedback received from themed conversations held with patients and also the linkages with the gap analysis undertaken on the Francis Report. Ms Crocket would, for the next Committee meeting, share the questions asked of patients, and provide an update on the recommendations from gap analysis from the Francis Report.

**Nurse Director**

Rev Dr Shanks enquired about the methodology of the patient conversations, how representative they were and how they were selected. Ms Crocket indicated that she would include this in her next paper to the Committee.

**Nurse Director**

NOTED

**12. OLDER PEOPLE IN ACUTE CARE: HEI INSEPTION SUMMARY REPORT**

There was submitted a paper [Paper No:14/09] from the Nurse Director providing an update on the Older People in Acute Care: HEI Inspections within NHSGGC since the last report submitted in May 2013. The paper also provided a summary of NHSGGC findings in comparison to other NHS Board's published reports.

In November 2013, a report on the review of the methodology and process for the inspection of the care of older people in acute hospitals was published and it outlined 19 recommendations. The majority of recommendations related to the HIS Inspection methodology and process for inspections. There were three main potential areas for consideration and these related to casenote review processes; medicine reconciliation dual application and the release of staff to participate in the HIS Older People in Acute Hospitals: Inspection process.

Since the last report to the Committee there had been one unannounced inspection to Gartnavel General Hospital in October 2013 and the report was awaited. There had also been a total of seven inspections to NHSGGC in all, which included two pilot inspections and the paper provided a summary of the inspections together with a number of findings from the reports against the key themes. A table was provided showing a summary by the NHS Board of the total number of inspection reports published, strengths, improvements and continuous improvements.

Ms Crocket advised that on a monthly basis, local inspection processes were now been undertaken within wards in NHSGGC using national guidance and with the inclusion of patient panel representatives. Mr Archibald indicated this internal inspection process was helpful and the Acute Services Nurse Director was also carrying out themed visits i.e. tissue viability. This aggregated approach was helping, however, there was a challenge when considering more internal inspections in order to bring about improvements. With over 400 wards within NHSGGC, a balance needed to be struck.

Dr Benton asked about cognitive impairment being picked up in assessment at Accident & Emergency, and also how seriously ill patients had their height and

weight measured. Ms Crocket advised that cognitive impairment was picked up when patient assessments were undertaken and she recognised that whilst the height and weight of patients was required to be undertaken within a certain time period, there could be challenges to this when the equipment was not always immediately available for certain patient conditions.

Ms Crocket advised that she had attended the feedback report following the unannounced visit to Gartnavel General. It had been generally fine however the report had attracted negative media coverage. Some aspects of the findings were heartening however, it was disappointing when similar issues from previous reports were identified as repeat problems and that was why consideration was being given to whether further internal inspections should be rolled out across the NHS Board area.

NOTED

### **13. REPORT ON THE CHAPLAINCY SERVICE 2013**

There was submitted a paper [Paper No:14/10] from the Director, Rehabilitation and Assessment providing the Annual Report on the Healthcare Chaplaincy Service within NHSGGC. The report aimed to give an overview of recent and ongoing developments and reflected on diversity of activity which falls under the heading of Specialist Spiritual Care. It was recognised that there was an increased interest in spirituality and spiritual wellbeing in NHS Scotland and the connection of these to person-centred care, personal and community resilience and staff experience was acknowledged.

Rev Dr Shanks indicated that he was encouraged by the fact that spiritual care had been embedded into hospital care and the service, whilst available for patients, was also made available to staff. This was a good report and a good contribution to health care.

NOTED

### **14. 2014-15 LOCAL DELIVERY PLAN GUIDANCE**

There was submitted a paper [Paper No: 14/11] from the Director of Corporate Planning and Policy setting out the process for considering the 2014/15 Local Delivery Plan Guidance. This was to be a transitional year towards supporting NHS Boards to embed the performance gains delivered during the last five years in addition to achieving the transformational change required to deliver NHS Scotland's ambition to be a world leader in quality care and its 20:20 Vision described through the Route Map.

The revised LDP Guidance indicated a move towards a more integrated approach to planning and had requested four elements, all of which will be underpinned by finance and workshop planning. These were:-

- Improvement and Coproduction Plan
- NHS Board contribution to community planning
- HEAT Risk Management plans and Delivery Trajectories
- A Strategic Assessment of Primary Care

The move to have a more integrated LDP which brought together all the various

planning, performance and reporting requirements of SGHD was welcomed by members. Ms Brown welcomed the inclusion of the Keys to Life Learning Disability Strategy which highlighted the stark inequalities faced by people with a learning disability. Ms Julie Murray, Director of East Renfrewshire CH(C)P was taking forward the review of learning disability services within NHSGGC and it was agreed that she be asked to present at a future NHS Board Seminar work on progress within this area. This could form part of the discussions at the February 2014 NHS Board Seminar on the preparation of the Local Delivery Plan.

**Director of  
Corporate  
Planning &  
Performance**

NOTED

**15. UPDATE FROM THE OCTOBER – NOVEMBER 2013 MID-YEAR ORGANISATIONAL PERFORMANCE REVIEWS**

There was submitted a paper [Paper No: 14/12] from the Director of Corporate Planning and Policy providing an overview of the cross-system and local key achievements and challenges which emerged from the Mid Year Organisational Performance Reviews.

The End of Year Review identified a number of system-wide achievements including:-

- Overall, a mid year in-balance financial position and on-schedule efficiency savings;
- Evidence of progress across each of the CH(C)Ps in working towards the Health and Social Care Integration agenda;
- The delivery of key HEAT targets including smoking cessation, alcohol brief interventions, child healthy weight, CAMHS, alcohol and drug waiting times and 18 week RTT;
- The progress of key capital projects on time and within budget including the new Southside Hospitals and the completion and opening of the New Vale Centre for Health and Care in West Dunbartonshire CH(C)P.

Members who chaired or who were members of CH(C)Ps welcomed the Organisational Performance Review process and its benefits to keeping key matters and key themes under significant focus.

Ms Micklem indicated that the District Nursing Review featured in the Glasgow City CHP actions and it had been planned to bring that matter to the January meeting of the Quality and Performance Committee. This was acknowledged and it was reported that the Corporate Management Team were still discussing the review, particularly the separate issue of the development of services as opposed to the changes and revisions to current work practices. This would be further discussed and an update or outcome covered at the NHS Board Seminar or the NHS Board members' Away Session on 13/14 February 2014.

**Director of  
Corporate  
Planning &  
Performance**

Councillor Lafferty highlighted the issue of bed days lost to delayed discharge. Mr Calderwood indicated that there continued to be a variable pace in achieving reductions in this area however, it was clear that the direction of travel across all CH(C)Ps was encouraging. There was a rise in demand across both Local Authorities and the NHS and the Change Fund monies of £19m was likely to come to an end and this would possibly form part of the discussion at the Board's Away

Day in terms of priorities/choices. There was full recognition of the challenges faced both by Local Authorities and NHS Boards with delayed discharges and this was a result of patients with more long-term conditions than had been the case previously.

NOTED

**16. 2012-13 ANNUAL REVIEW – SCOTTISH GOVERNMENT FEEDBACK LETTER**

There was submitted a paper [Paper No: 14/13] by the Chief Executive providing the Committee with the SGHD letter setting out the outcome of the NHS Board's 2012-13 Annual Review. The letter summarised the main points discussed and the actions arising from the review.

The Mid Year Review would be held on 11 February 2014 and the Chief Executive would be accompanied by the Director of Finance in a meeting with the Director General and Director of Finance of NHS Scotland. There would be a particular focus on achieving the break-even position financially in 2014/15, winter pressures and achieving the 18 week RTT.

Mr Sime welcomed the acknowledgement of the local implementation of the values in the 2020 Workforce Vision via the Facing the Future programme and Mr Robertson provided an update on the meeting the Cabinet Secretary had with non-executive members as part of the Annual Review process.

NOTED

**17. FALLS GOVERNANCE REPORT**

There was submitted a paper [Paper No: 14/14] by the Nurse Director providing an update on the current position of the falls recorded and monitoring across the NHS Board and a description of the future planned developments in this area.

Within the Acute Services Division, the reported incidence of falls continued to decline on previous years although projecting the six month data for 2013 to the end of the year may indicate a slight increase in the Rehabilitation and Assessment and the Women and Children's Directorates.

Within Partnerships, District Nurses assessed patients in their own homes for risk of falls as part of the standardised nursing assessment documentation within 36 hours of the first visit. All patients referred to the Community Falls Team were fully assessed for their risk of falls and preventative measures were put in place to try and avoid future falls.

In developing the monitoring arrangements of the incidence of falls, in future it was planned to include the incidence of falls per occupied bed days with the intention of meeting the data requirements for the Older People in Acute Care Inspection processes.

The Scottish Patient Safety Indicator for falls in Acute Services included a 25% reduction in the number of falls by December 2015 and a 20% reduction in the number of falls with harm by December 2015. The Corporate Falls Steering Group would take forward this work, linking with the Clinical Governance Support Team

and local services to integrate this programme within current workstreams. Work was still to be undertaken which would link falls with significant clinical incidents.

NOTED

**18. MEDIA COVERAGE OF NHSGGC NOV-DEC 2013**

There was submitted a paper [Paper No: 14/15] by the Director of Corporate Communications highlighting outcomes of media activity for the period November - December 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.

There was a significant increase in the volume of media reports about NHSGGC due the coverage of the helicopter crash into the Clutha Vaults bar on 29 November 2013. Coverage was broadly factual but neutral although there were a number of positive reports about the response of NHS staff to the incident and in particular the hundreds of staff who came to work outwith their normal shift pattern to help respond to the emergency.

NOTED

**19. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2013**

There was submitted a paper [Paper No: 14/16] by the Director of Finance setting out the financial monitoring report for the eight month period to 30 November 2013. The NHS Board was reporting an expenditure outturn of £3.7m under budget and to assist in funding the transitional costs of the move to the New Southside Hospital, it was anticipated that a year-end surplus of circa £8m would be achieved in terms of carrying forward that sum to 2014/15.

The Director of Finance indicated that following a request from members for greater detail in the finance report particularly around the allocation of resources and in-year movement in resources, he had added two additional sections to the Financial Monitoring Report. He explained each in detail and sought members' comments on the provision of this additional information. Members welcomed this new presentation of information and Mr James indicated that he would also be meeting with Mr Lee and Mr Finnie on 27 January to further discuss any other requirements that members would find useful in terms of providing a full and detailed Financial Monitoring Report to the Quality and Performance Committee and NHS Board.

Mr Lee enquired as to the steps being taken to ensure the full allocation of capital funds was committed in 2014/15. Mr James advised that the Chief Executive had recently reviewed the current expenditure against the Board's Capital Plan, recognising some slippage had occurred. He had agreed a series of actions in order to assist in achieving a balanced outturn at the end of the financial year. Discussions had commenced with SGHD about a brokerage arrangement for £5m from this to the next financial year and certain expenditures had been brought forward in order to achieve a balanced capital allocation outturn.

NOTED

**20. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 31 OCTOBER 2013**

There was submitted a paper [Paper No: 14/17] enclosing the minutes of the Quality Policy Development Group meeting of 31 October 2013.

NOTED

**21. STAFF GOVERNANCE COMMITTEE MINUTES OF MEETING HELD ON 19 NOVEMBER 2013**

The minutes of the Staff Governance Committee held on 19 November 2013 [SGC(M)13/04] were submitted to the Committee.

NOTED

**22. NEW SOUTH GLASGOW HOSPITALS PROGRESS UPDATE – STAGES 2 & 3**

There was submitted a paper [Paper No:14/18] 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 relation to Stage 2, the project team have reviewed and returned the updated equipment list to the contractor for finalisation. Piling works for the vacuum insulated evaporator compound were completed on 22 November 2013 and foundation works had subsequently progressed.

In relation to Stage 3, as at 31 December 2013, 144 weeks of the 205 week contract had been completed and the project remained within timescale and budget. Contract completion was 28 February 2015 and Mr Loudon provided members with images and a presentation highlighting the progress of both hospitals.

In relation to car park 1, dialogue continued with the sub-contractor to identify how the current works could be re-sequenced/accelerated to mitigate the current delay in the programme. Currently the car park was due for completion in May instead of April 2014.

In relation to the Teaching and Learning Centre, the Full Business Case was approved by the Scottish Government Capital Investment Group on 14 November 2013 and the construction phase commenced on 18 November 2013 and the piling works subsequently commenced on 9 December 2013.

In relation to the new Staff Accommodation (Office) Building, the Full Business Case was considered and approved at a meeting of the NHS Board on 17 December 2013. The Full Business Case had subsequently been submitted to the Scottish Government Investment Sub-Group for consideration at their meeting to be held on 28 January 2014. Full planning approval from Glasgow City Council was granted on 12 December 2013.

Mr Ross advised that there had been no new compensation events since the last meeting of the Committee.

Mr Lee asked about the EFTE roof and in particular how it would be cleaned and Mr Loudon advised that it was designed as a self-cleaning roof via rainwater and consideration would be given to the possibility of an annual clean. Mr Williamson asked about the transfer of existing equipment and Mr Loudon advised that a further review was now being undertaken to ensure there was an up-to-date assessment of what equipment could sensibly transfer and what would be required to be purchased at the time of the move into the new hospitals.

Mr Fraser asked about the BREAM process and Mr Loudon advised that a BREAM consultant was on site and there was an element of self inspection and external inspection in order to bring an independence to the outcome.

NOTED

**23. INVERCLYDE COUNCIL COMMISSIONED SERVICES FOR SPECIALIST NURSING CARE, OLDER PEOPLE'S DEMENTIA AND ADULT MENTAL HEALTH INTENSIVE SUPPORTED LIVING SERVICES**

There was submitted a paper [Paper No: 14/20] by the Director of Glasgow City CHP providing the Outline Business Case for the Inverclyde Adult and Older People's Mental Health Continuing Care facility with the request that it be approved for submission to the Scottish Government Capital Investment Group meeting on 11 March 2014 for approval to progress to Full Business Case.

HUB West of Scotland (Scottish Futures Trust) would be responsible for the development of the facility and the project was part of the Clyde Modernising Mental Health Strategy which set out the guiding principles and supporting evidence behind the proposals to modernise and rebalance mental health services in Clyde. The project would provide a new facility for 42 NHS Mental Health Continuing Care beds, 30 for older people and 12 for adults. The site for this development was adjacent to the Inverclyde Royal Hospital on land owned by NHSGGC (previously used as staff accommodation). The site would be leased to HUB West of Scotland for 25 years – the contract period. The new facility would replace services currently on the Ravenscraig Hospital site and would be the final step in closing the hospital in October 2015.

Councillor McIlwee congratulated the team in reaching this point and was pleased that finally services would be transferred from the outdated facilities at Ravenscraig Hospital, and was supportive of the proposal. Mr Williamson considered this a well put together Outline Business Case and proposal which was well overdue.

Ms Brown welcomed the proposal however, was keen to receive reassurance about the patient mix at the facility and whether this would be covered in the Final Business Case in terms of the accommodation/design. She was keen to see a separation between the 12 adult beds and the 30 beds for older people. Mr Mitchell advised that in terms of design, the 30 bedded unit would be separated from the 12 bedded area by a large public area in the middle. This would be shown in the Full Business Case.

DECIDED

- That the Outline Business Case for the Inverclyde Adult and Older Peoples Mental Health Continuing Care Facility be approved for submission to the

**Director of  
Glasgow City  
CHP**

Capital Investment Sub-Group meeting on 11 March 2014.

**24. HUB PROGRAMME UPDATE INCLUDING MARYHILL HEALTH CENTRE AND EASTWOOD HEALTH & CARE CENTRE – FULL BUSINESS CASE APPROVAL ARRANGEMENTS**

There was submitted a paper [Paper No: 14/19] by the Director of Glasgow City CHP setting out the progress with each scheme under the auspices of the Hubco Development Programme for NHSGGC. This included Maryhill Health Centre, Eastwood Health and Care Centre, Gorbals and Woodside Health Centre and East Pollokshields Primary Care Centre.

In relation to the Maryhill Health Centre and Eastwood Health and Care Centre, the Outline Business Case for both projects had previously been approved by the Quality and Performance Committee and the Scottish Government Capital Investment Group. The next approval arrangements were for the Full Business Cases (FBCs) which included a more detailed financial analysis for the proposed facilities. A core requirement was that the FBC demonstrated that the cost of the project was within the agreed affordability cap and that the financial profiles had been developed in such a way as to demonstrate that the project provided value for money. Mr Curran advised that an updated timescale had been requested by SGHD and that the request was for approval by the Quality and Performance Committee by 4 February 2014 and submission to the SG Capital Investment Group for consideration at its meeting on 11 March 2014. It was acknowledged that this would require delegated authority to take decisions outwith the meeting.

Mr Curran advised that the Stage 1 process of the Hubco arrangement had returned a market price which was too high and steps were required to reduce excessive costs. Mr Calderwood asked how affordability was achieved. Mr Curran advised that the mechanical and engineering specification for Maryhill Health Centre had been set at a higher standard than any of the previous health centres. Steps had been taken to find a balance such as reducing the air conditioning provision within the whole facility to only providing it within those areas it was required to ensure this South facing building would have adequate comfort cooling when required. Mr Curran advised that Hubco were, as a result of these steps, more confident that a more acceptable market price would be achieved this time around.

It was agreed that the Full Business Cases would be submitted to the members of the Quality and Performance Committee as soon as practical and any queries would be raised with the Convenor and once satisfied, the Convenor would then approve on behalf of the Committee, the Full Business Cases for submission to the Capital Investment Group meeting on 11 March 2014.

Mrs Hawkins gave an update on the replacement of the Gorbals and Woodside Health Centres and advised that the Outline Business Cases would be submitted to the May meeting of the Quality and Performance Committee for consideration.

**Director of  
Glasgow City  
CHP**

With regard to East Pollokshields Primary Care Centre, she advised that the site has been secured from Glasgow City Council and planning permission obtained. The scheme was within the affordability cap set for the project and financial closure was expected at the end of January/early February 2014 with a start date on site in February and completion by October 2014. The capital expenditure had come from the Primary Care Modernisation Fund in 2008 and whilst the CHP Committee and Capital Planning and Property Group had viewed and approved these costs, it was acknowledged that a Business Case had not been submitted to the Quality and

Performance Committee for approval. Mrs Hawkins regretted that this had not occurred on this occasion and sought agreement to the Committee delegating approval of the Business Case under the same set of arrangements agreed for the FBC for Maryhill and Eastwood Centres.

Mr Lee pointed out that the minutes of the Capital Planning and Property Group meeting in February 2013 which had considered and approved this scheme, had unfortunately not been submitted to the Quality and Performance Committee for noting. He was keen that the approval limits set out in the Quality and Performance Committee remit be re-circulated in order that key staff and groups were sighted on the requirement to obtain the Quality and Performance Committee approval for appropriate schemes.

**Director of  
Finance**

DECIDED

- 1) That, the progress with each scheme under the auspices of the Hubco development programme for NHSGGC be noted.
- 2) That, the approvals process for Maryhill Health Centre and Eastwood Health and Care Centre, Full Business Cases be delegated to the members to consider outwith the meeting and provide any comments to the Convenor and when these had been answered/satisfied, the Convenor approve on behalf of the Committee the Full Business Case to be submitted to the SG Capital Investment Group for its meeting on 11 March 2014.
- 3) That the Business Case for the East Pollokshields Primary Care Centre be submitted to members outwith the meeting for consideration with comments to be submitted to the Convenor and once answered/satisfied, the Convenor be delegated the authority to approve the Business Case and to allow the start on site to commence on 14 February 2014.

**Director,  
Glasgow City  
CHP**

**Director,  
Glasgow City  
CHP**

**25. CAPITAL PLANNING AND PROPERTY COMMITTEE GROUP MINUTES – MEETINGS HELD ON 29 JULY, 16 SEPTEMBER, 25 OCTOBER AND 29 NOVEMBER 2013**

There was submitted a paper [Paper No: 14/21] enclosing the minutes of the Capital Planning and Property Group meetings of 29 July, 16 September, 25 October and 29 November 2013.

NOTED

**26. PROPOSAL FOR THE DEVELOPMENT OF A RADIOTHERAPY AND IMAGING RESEARCH CENTRE AT THE BEATSON WEST OF SCOTLAND CANCER CENTRE (BWOSCC) ON THE GARTNAVEL GENERAL HOSPITAL SITE**

There was submitted a paper by the Chief Executive [Paper No: 14/22] asking the Committee to note the proposal from Beatson Cancer Charity to raise funds to construct and run a new radiotherapy and imaging research centre on the site of the current virology laboratory on Gartnavel campus.

The intention was that the charity raised funds to finance the construction of the centre, the purchase, installation and commissioning of a state of the art linear accelerator, MRI, CT and possibly PET, the recruitment, salaries and on-costs for

11.5 WTE clinical, research and administrative staff for five years. It was anticipated that the centre would become self-funding through research grants and academic contracts after the initial five year period. Total project costs with five years of funding would be in the region of £22.5-25m.

The Beatson Cancer Charity wished to seek the NHS Board's approval to secure the site currently occupied by the virology laboratory on the Gartnavel campus, adjacent to the Beatson West of Scotland Cancer Centre. The virology laboratory was currently being transferred to Glasgow Royal Infirmary and would not be required for any developments at the Gartnavel site.

Mr Williamson indicated that there had been discussions at the Endowment Trustees Committee about another development and this was an encouraging proposal with direct patient benefits for those from the West of Scotland. The challenge would be in raising the required funding. Mr Calderwood acknowledged this and indicated that the Beatson Cancer Charity was seeking approval in principle at this stage for reserving the land.

DECIDED

- That, the Beatson Cancer Charity proposal that the land at the current virology laboratory on the Gartnavel campus be retained for the proposed construction of a new radiotherapy and imaging research centre be approved in principle.

**Chief Executive**

**27. DATE OF NEXT MEETING**

9.00am on Tuesday 18 March 2014 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:55pm