QPC(M)14/02
Minutes: 28 - 51

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Quality and Performance Committee at 9.00 am on Tuesday, 18 March 2014 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	Ms R Micklem
Dr H Cameron	Cllr J McIlwee
Mr P Daniels OBE	Mr D Sime
Mr I Fraser (To Minute No:45)	Mr B Williamson

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	Cllr M O'Donnell
Ms R Crocket MBE	Dr R Reid
Mr R Finnie	Mr A O Robertson OBE

Rev Dr N Shanks

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

Mr G Archibald	..	Director of Surgery and Anaesthetics
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 No: 49)
Mr A MacKenzie	..	Director, Partnerships (To Minute No: 31(b))
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting
Ms C Renfrew	..	Director of Corporate Planning and Policy
Ms H Russell	..	Audit Scotland
Dr M Smith	..	Lead Associate Medical Director, Mental Health (For Minute No: 42)

28. APOLOGY

An apology for absence was intimated on behalf of Councillor M Cunning.

29. DECLARATIONS OF INTEREST

There were no declarations of interest raised.

30. MINUTES OF PREVIOUS MEETING

On the motion of Mr I Fraser and seconded by Councillor J McIlwee, the Minutes

of the Quality and Performance Committee Meeting held on 21 January 2014 [QPC(M)14/01] were approved as a correct record.

31. MATTERS ARISING

(a) Rolling Action List

(i) Minute 12 – Older People in Acute Care: HEI Inspection Summary Report

Mr Winter referred to the HEI Inspection carried out at Gartnavel General Hospital in October 2013 and advised that in reading the full report, he had been concerned about the number of issues raised particularly in relation to forms not being filled in and the lack of proper recording of relevant clinical information. Mrs Crocket advised that a full action plan was in place for each of the action points identified and there was a range of care planning audits undertaken, auditing of record keeping and reporting to clinical governance structures in relation to nursing and other core audit activity. The difficulty was in sustaining this effort and ensuring consistency across the NHS Board's area. Further reporting on HEI inspections would include the actions being undertaken in relation to better record-keeping and the monitoring of this activity. **Nurse Director**

(ii) Minute 139 – Financial Monitoring Report

Mr James advised that issues relating to prescribing and the impact of UK arrangements with the pharmaceutical industry would be covered in the financial plan which would be discussed at the April NHS Board Seminar. **Director of Finance**

NOTED

(b) Maryhill and Eastwood Health and Care Centres - Update

There was submitted a paper [Paper No: 14/24] by the Director, Glasgow City CHP providing an update on the approval process of the Final Business Cases (FBCs) for both Maryhill Health Centre and Eastwood Health and Care Centre. Both projects had been bundled into one agreement to be provided by Hub West of Scotland as part of the Scottish Government's approach to the delivery of new community infrastructure.

The January meeting of the Quality and Performance Committee had agreed that the Full Business Cases for both health centres, due to time constraints, be considered outwith formal meetings and if members were satisfied with the proposals, it was delegated to the Convener of the Committee to approve the Business Cases for submission to the Scottish Government Capital Investment Group meeting on 11 March 2014. The members of the Committee queried aspects of the proposals and, based on the answers given, supported the proposals and thereafter the Convener approved the Final Business Cases for Maryhill Health Centre and Eastwood Health and Care Centre on 21 February 2014. Both FBCs were considered by the Capital Investment Group at its meeting on 11 March 2014 and were approved in principle with a number of points to be clarified and finalised prior to financial close on 29 April 2014. The

issues raised were:-

- Provide the most up-to-date costings for each project and ensure that these were reflected in the FBCs;
- Ensure the Risk Register was updated;
- Take note of the recommendations from Architecture and Design Scotland.

If these outstanding matters were concluded, the start on-site for both projects was June 2014 with anticipated completion for the Maryhill Health Centre in August 2015 and for the Eastwood Health and Care Centre, October 2015.

In noting the current position, members requested that the arrangements associated with Hub projects be a topic for a future NHS Board Seminar. **Head of Board Administration**

NOTED

32. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No: 14/25] 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:-

- Access to psychological therapies had moved from red to green;
- A&E waits maximum four hour stay had moved from amber to red;
- Overtime usage had moved from green to amber.

Exception reports had been provided to members on the nine measures which had been assessed as red and this had included an exception report on A&E waits of a maximum of four hours.

Mr Shanks was pleased at the progress with psychological therapies but wondered if the A&E waits had been related to the difficulties experienced with delayed discharges. Mrs Hawkins acknowledged this and explained that fortnightly meetings were being held between Glasgow CHP and the City Council to seek improvements in this area. Her presentation at the Board Away Day had focused on the figures up until January 2014 and some improvements were coming through in the figures for February. Whilst resources had been increased in the south of Glasgow, there was an impact in the reduction of funding for nursing home places, industrial action and a number of staff absences in the early part of 2014. It was recognised that a solution required a whole system approach and all parts needed to work well. Mr Archibald emphasised this by describing the seasonal impacts, moves to early morning hospital discharges and attempts to reduce the number of inappropriate hospital admissions.

Mr Finnie recognised the challenge for the NHS Board particularly if the funding associated with the Change Fund, which had been helpful in identifying bottlenecks and speeding up the process, was withdrawn. There was recognition that there was far less flexibility with capacity and this would become even more difficult in future years as further efficiencies were required to be made. An analysis of the Change Fund and what had been achieved would be presented to members later in the year. **Director, Corporate Planning & Policy**

Dr Benton enquired about the issuing of medication to patients upon discharge. Mr Archibald acknowledged that although some progress had been made there was still a need for better organisation of medications being ready for patients being discharged, particularly if there were moves to discharge patients earlier in the morning.

NOTED

33. SCOTTISH PATIENT SAFETY PROGRAMME: UPDATE

There was submitted a paper [Paper No: 14/26] setting out the progress against the Scottish Patient Safety Programme (SPSP). In particular, the paper set out the update on the treatment of the ten safety essentials which had been described in the CEL 19 (2013).

The first four safety essentials related to the critical care workstream which applied to ITU settings. ITUs have processes in place for recording infection rates linked to the clinical care processes, meaning that the reliability and effectiveness of the clinical process can be tracked through an already established process of outcomes monitoring. The next four safety essentials related to the general ward workstream. The Early Warning Scorecard charts had achieved a high level of spread, having been embedded in the ongoing work around deteriorating patients. The remaining actions were underway and the leadership walkrounds were ongoing and attended by Non-Executive Members of the Board and would remain a feature of the regular reporting framework.

The NHS Board had recently hosted a review visit from Healthcare Improvement Scotland and the National Clinical Lead for Safety. The write up from this report would be provided to a future meeting of the Quality and Performance Committee. **Medical Director**

Ms Micklem enquired about the number of targets and measures to be assessed as she continued to have a concern about the increase. Dr Armstrong advised that whilst clearly there were more measures and therefore more data collection, it had been important to focus on those which were most important and those which gave the greatest learning. She was hopeful that collecting data electronically would make these tasks easier and less labour intensive and she had been having discussions with the Director of Health Information and Technology to see if assistance could be given in this area. She would update the committee in due course. **Medical Director**

NOTED

34. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No: 14/27] by the Medical Director providing

an exception report on the NHS Board performance against HEAT and other HAI targets.

Dr Armstrong advised that the position on SABs remained the same as reported at the meeting of the Committee in January 2014 when the last validated figures for the quarter July-September 2013 had been presented. She was able to say however, that the unvalidated figures for January, February and March had shown a continued downward trend and this had been welcomed.

Ms Brown was pleased to hear about the recent downward trend but asked in particular, whether the overall responsibility now lay with the Charge Nurse for lines inserted into patients; the reasons for no longer capturing the date and time of cannulla insertion and if the actions taken to improve performance in this area were sustainable. Dr Armstrong agreed that the policies which had previously been developed by different hospitals had been inconsistent and the infection control team had now introduced a consistent policy across NHSGGC which gave the responsibility to the Charge Nurse in relation to regularly reviewing the line and questioning the doctor on a regular basis as to its continued purpose. She advised that no evidence had been produced that recording the date and time of the cannulla insertion made any specific difference; and the conclusion had been that too much time had been spent on something which was not making a difference and it was important to spend that time on the care plan approach and achieve a higher compliance which would have a greater overall benefit for the patient. She was hopeful that these two actions and the other actions as part of the action plan to reduce SABs would ensure sustainability of the improving performance.

Ms Brown asked about patients returning to the community with infections and Dr Armstrong advised that for those serious infections, these would be picked up and reviewed on readmission to hospital and then tracked back to the ward or clinical setting in which the patient had received treatment.

NOTED

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

There was submitted a paper [Paper No: 14/28] by the Medical Director on the handling of adverse clinical incidents together with an update on the current fatal accident enquiries. Dr Armstrong tabled a revised Figure 1a – Time Sequence Chart of Significant Clinical Incidents Reported in Acute Services Division per month (April 2008 - February 2014). This showed a more stable picture of reported significant clinical incidents and Dr Armstrong explained that when running the report at the end of the month, there had still been some potential SCIs awaiting a decision as to whether they should be investigated as SCIs.

Dr Armstrong advised members that there had been three recent maternal deaths and she was having each one investigated and would advise the Committee of the outcome of these investigations. In relation to the Fatal Accident Inquiries, she advised that the Sheriff's determination was due on 19 March in relation to the lady who had been admitted 34+ weeks pregnant with chest pain in November 2008 and had become seriously unwell and was admitted to the high dependency unit within the labour ward. Regrettably the lady had passed away and a peri-mortem caesarean section was performed with a live baby delivered. The Sheriff's determination would be passed to members when received. **Medical Director**

Medical Director

NOTED

36. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 3 FEBRUARY 2014

There was submitted a paper [Paper No: 14/29] in relation to the Board Clinical Governance Forum meeting held on 3 February 2014. Dr Armstrong gave an update on the steps taken to improve the use and efficiency of the Datix recording system. Funds had been allocated to purchase a new server and other improvements had been identified and made as a result of the Datix Working Group's review of the functionality and use of Datix. It had been noted that there was still a high number of overdue incidents which had not been closed off, and taking action on this point remained a priority.

Ms Brown asked about the serious clinical incidents in mental health which had not been fully reported through the briefing note/rapid alert system. Dr Armstrong advised that a reminder had been sent to Heads of Mental Health and Partnership Directors to follow the guidance issued and ensure that the Medical Director and Nurse Director were included in the distribution. This particular situation had been highlighted in relation to one particular case which had not been escalated to the Medical or Nurse Director.

NOTED

37. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 OCTOBER – 31 DECEMBER 2013

There was submitted a paper [Paper No: 14/30] from the Nurse Director setting out the actions taken by the responsible operational area in response to recommendations made by the Scottish Public Services Ombudsman in investigative reports and decision letters.

The report covered one investigation report and 20 decision letters relating to ten within Acute Services, six within Partnerships and four within the Family Health Services. There was a total of 39 issues investigated of which 12 issues were upheld. The Ombudsman had made 23 recommendations. The report had also included the outcome of three cases from the previous quarter.

Mr Finnie continued to be concerned that the Ombudsman had investigated cases where the patient remained dissatisfied and had reviewed the same heads of complaints which Board staff had and yet was able to uphold issues which NHS Board staff had failed to identify. He was aware of work being undertaken to make improvements in this area but he felt that there still needed to be a change of culture with a far more open and less defensive approach to handling complaints at the local resolution stage. Ms Crocket acknowledged that continued concern and explained some of the actions which had been recently put in place including second episode complaints being reviewed by a different Director and the Chief Executive now writing to Directors seeking reasons why the Ombudsman was able to uphold a complaint which had not been upheld following the Board's own investigation. In addition, a Corporate Session had been arranged for 25 March 2014 at which all Senior Directors and both clinical and other mangers involved in complaints would be present to hear presentations from the Chief Executive, the Scottish Public Services Ombudsman and the Nurse Director. It was hoped that through the session, the message would be clear that there was a drive from the top

to lead to a far more compassionate and empathetic stance taken on complaints and that an improvement in this area was a priority for the Board.

Mr Fraser did however, indicate that he was pleased with the downward trend in upheld issues and thought the actions already put in place had begun to show significant improvements in complaints handling.

NOTED

38. INEQUALITIES – UPDATE ON PROGRESS

There was submitted a paper [Paper No: 14/31] by the Director of Corporate Planning and Policy and the Director of Public Health setting out the progress on the actions agreed at the April 2013 NHS Board Seminar when it had been highlighted that there was a significant difference in life expectancy, mortality and morbidity between the most and least affluent communities within NHSGGC and also the considerable health gap between areas within NHSGGC and the rest of Scotland. The Seminar had also identified how health improvement, health services and influencing wider determinants through partnership working were currently contributing to addressing inequalities and reflected on whether there were any issues which still needed to be addressed.

Ms Micklem welcomed the report but was disappointed with the review of health improvement resources in relation to need and the outcomes delivered and that the Keep Well project was not to be funded from 01 April 2014. In relation to the identification of good practice in other areas which had made a significant impact in improving the gap in health outcomes, there was little evidence in the report showing that this had been done. Lastly, she did not believe that the template for NHS Board and Committee papers reflected equalities dimensions systematically. Ms Renfrew acknowledged the frustration at the decision on Keep Well and Dr De Caestecker would look further at the review of health improvement resources and provide feedback to the next meeting as to whether further improvements could be made in relation to need and outcomes. Ms Renfrew acknowledged that there was good practice within NHSGGC however there needed to be a more comprehensive scope of good practice within other areas and would look more widely. In relation to the template of Board/Committee papers, it was agreed that further thought required to be given to this to reflect equalities dimensions in a more significant and helpful way.

Director of Public Health

Director, Corporate Planning and Policy

NOTED

39. NHSGGC ACCESS POLICY EQIA ACTION PLAN: UPDATE

There was submitted a paper [Paper No: 14/32] by the Lead Director, Acute Services asking members to note the update on the Access Policy EQIA Action Plan. Mr Archibald advised that there were no great variances within waiting times although the auditors were currently reviewing performance in this area. The six month average had been 26.2 days and the one outlier had been the Vale of Leven Hospital where patients had wished to remain at the Vale of Leven rather than attending any other hospital. These issues would be considered together with the update of the action plan at the next meeting of the Access Group in April.

Ms Micklem welcomed this helpful update although she was concerned at the performance of “did not attends” and despite all the actions taken, this was one area

that was still getting worse.

NOTED

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

There was submitted a paper [Paper No: 14/33] by the Nurse Director setting out the current position on the NHS Board's progress in implementing the National Collaborative for Person-Centred Health and Social Care. The paper provided briefings on the approach, progress and the current action plan. A brief outline of a themed conversation was included as requested by the Quality and Performance Committee and an illustrative case study was also included to showcase a qualitative description of the local approach within a clinical team.

Ms Brown was pleased to read about the success described in the case study but was worried about how it would be possible to achieve this level across the Board and in a consistent way. It worked best in the places where it was possibly needed least. Ms Crocket indicated that clearly, working with enthusiastic teams provided good outcomes and learning opportunities. She agreed that it was critical to share this across other areas and support its development in areas that needed it most. She felt that this would be best achieved by trying to ensure that it was made real for staff on the frontline and that they were contributing thoughts and ideas to bring about such improvements. It was a huge challenge but the early successes had proven thus far that it was possible to make a difference.

NOTED

41. UPDATE ON THE FRANCIS REPORT

There was submitted a paper [Paper No: 14/34] from the Nurse Director asking the Committee to note the progress to date on the implementation of the recommendations from the review of NHSGGC's position in relation to the recommendations for improvement within the Francis Report. A Short Life Working Group made up of staff from a range of backgrounds had been established to undertake this work and they consulted a range of key individuals across the NHS Board. Following the publication of a detailed report, the working group had concluded that there was evidence that the Board did have the necessary tools in place to support and provide high standards of care. The progress of the implementation of the recommendations was to be tracked through a range of governance arrangements including the Board Organisational Development Group, Clinical Governance Forum and the Quality Policy Development Group. Some of the areas for further improvement included:-

1. Supporting and encouraging a bottom-up approach to listening and responding to patients and their families;

2. Supporting front-line staff to feel more confident in engaging with patients and their families who are unhappy about services;

3. Continuously develop a culture where staff feel empowered and proactively listened to;

4. Ready access to data that supports and demonstrates the quality of

care/services afforded to patients.

Ms Brown wondered if it would be possible to bring together a composite report covering person-centredness, the Ombudsman's report, the Francis Report, significant clinical incidents and the staff survey to highlight all the key actions into one paper so that it was joined-up and integrated around the patient. Mr Sime felt that these were all different strands of work which drove different outcomes and that most of the information sought already came to the Quality and Performance Committee.

Ms Micklem felt that it was also critical to include culture and leadership and the underpinning values which supported the organisation in delivering a high standard of patient care. This could be linked to the content of the leadership programme which was currently being reviewed.

Ms Renfrew felt it was worthwhile for officers to discuss how to bring all this together which could incorporate the work of the Francis Group, Quality and Development Group and Organisational Development Group. It was recognised that not all actions would come together within the same timeframe or quarter but it would be best to concentrate on completed issues initially. Such an outcome could be referred back to the Francis Report recommendations to show where each action/improvement had been made.

If this proved feasible, Ms Brown would then be keen to ensure that the messages in such a report would be communicated to staff. Mr Williamson reminded members that there was a huge difference between the management and clinical aspects in Mid-Staffordshire than there was with NHSGGC and the important issue for the NHS Board was both listening to and learning from reports such as the Francis Report. Dr Armstrong said there was no doubt that patient expectation had been raised and this had to be responded to. However, clinical leadership also needed to be improved, and this was one of the gaps identified from the Francis recommendations. Bringing together clinical performance and feeding it into an "easy to read" paper would not be straightforward. Mr Finnie echoed this and felt that complex workstreams should not be muddled. The issues which were easy to be merged should be merged and matters should not be overcomplicated.

Consideration would be given to what could be sensibly brought together into an overarching report. **Nurse Director**

NOTED

42. SUICIDE PREVENTION IN NHSGGC

There was submitted a paper [Paper No: 14/35] from the Director, Glasgow City CHP and Associated Medical Director, Mental Health which provided the context for suicide reduction within the NHS Board's area and an update on current action plans and intended plans.

Over the last decade, suicide and non-fatal self harm had become increasingly recognised as an important issue for public health policy and practice in Scotland, in part because suicide rates were significantly higher in Scotland compared to the rest of the UK. There were 830 suicides registered in Scotland in 2012 which included 193 deaths in the NHSGGC area. Although deaths from suicide in NHSGGC and Scotland continued to fall (down 18% in ten years) they had risen slightly over the last decade in England and Wales. Economic recession, especially

unemployment, has been clearly shown to be associated with increased suicide rates across Europe.

Dr Smith, in presenting the paper, also highlighted the suicide prevention actions undertaken by the Greater Glasgow and Clyde Suicide Prevention Planning Group and the paper gave specific details of the eight point work plan agreed by the group.

Mr Williamson asked if there was evidence that the Samaritans were effective and if their work had connections with the NHS. Dr Smith indicated that no formal study had been carried out, however compassion was an important part of prevention and the Samaritans played an important role in this area and many could learn from their experiences. Formal links did exist and their leaflets and telephone numbers were freely available within the NHS.

Mr Fraser commended the excellent paper and presentation and was pleased to read of the steps being taken within the Board's area in trying to further reduce suicides in NHSGGC.

Ms Micklem noted that people were three times more likely to commit suicide if they were from deprived areas and she wondered if the overall reductions could be shown across all social groups. She was also keen to know whether there were specific actions targeted at males in deprived areas. Dr Smith was not aware if the reductions were across all social groups but work was being undertaken in this area and he confirmed the actions taken in terms of training and liaison with benefit agencies and prisons to target messages to males from deprived areas. Mrs Hawkins indicated that custody suites in prisons would have health care provided in future and this would be a real opportunity to make a difference in this area.

NOTED

43. MEDIA COVERAGE OF NHSGGC JAN-FEB 2014

There was submitted a paper [Paper No: 14/36] from the Director of Corporate Communications highlighting outcomes of media activity for the period January/ February 2014. 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

44. FINANCIAL MONITORING REPORT FOR THE 10 MONTH PERIOD TO 31 JANUARY 2014

There was submitted a paper [Paper No: 14/37] by the Director of Finance setting out the financial monitoring report for the ten month period to 31 January 2014. The NHS Board was reporting an expenditure outturn of £7.1m under budget in order to assist in funding the transitional costs of the move to the New South Glasgow Hospital. It was anticipated that a year-end surplus of circa £10m would be achieved in terms of carrying forward that sum to 2014/15. This would be formally reported in the Month 11 report.

The Director of Finance drew members' attention to the changes in presentation with more analysis of costs and changes in income reporting. He took members through the detail of the report and the changes to it.

Members welcomed the presentation changes and felt that the report was enhanced by the additional information shown.

NOTED

45. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 18 DECEMBER 2013

There was submitted a paper [Paper No: 14/38] enclosing the minutes of the Quality Policy Development Group meeting of 18 December 2013.

NOTED

46(a) STAFF GOVERNANCE COMMITTEE MINUTES OF MEETING HELD ON 18 FEBRUARY 2014

The minutes of the Staff Governance Committee held on 18 February 2014 [SGC(M)14/01] were submitted to the Committee.

NOTED

46(b) STAFF GOVERNANCE COMMITTEE REMIT 2014

There was submitted a paper [Paper No: 14/39] by the Director of Human Resources setting out the recommended changes to the Remit of the Board Staff Governance Committee.

The Staff Governance Committee had reviewed its remit at its meeting in February 2014 and had made recommendations for specific changes.

DECIDED

- That the revised remit of the Staff Governance Committee be approved.

47. QUALITY AND PERFORMANCE COMMITTEE – REVISED REMIT

There was submitted a paper [Paper No: 14/40] by the Head of Board Administration setting out the revised remit of the Quality and Performance Committee for members' consideration.

The revised Quality and Performance Committee remit had been produced following discussions at the Audit Committee on the Standing Financial Instructions in relation to the limit for approval of Capital and IM&T Schemes and property transactions. The revised remit had also taken account of the discussions with the Chief Executive who was keen to keep a significant scrutiny/approval role for the Quality and Performance Committee in relation to Capital Schemes, IM&T Schemes and property matters.

DECIDED

- That, the revised Quality and Performance Committee remit be approved for submission to the April Board for endorsement. **Head of Board Administration**

48. ADULTS WITH INCAPAPCITY (SCOTLAND) ACT 2000 – ANNUAL REPORT FOR 2013 ON THE OPERATION OF PART 4

There was submitted a paper [Paper No: 14/41] by the Director, Glasgow City CHP asking the Committee to note the Annual Report produced by the Adults with Incapacity Supervisory Body covering the discharge of the Board's obligations under Part 4 of the Adults with Incapacity (Scotland) Act 2000. The Act required the making of arrangements for the management of funds of those patients resident in NHSGGC hospitals who lacked the capacity to make decisions about their own finances. The report was presented to provide assurance to the Committee that the Supervisory Body was fulfilling its obligations under the Act.

Mr Lee reminded members that this was the last meeting which Mrs Anne Hawkins would be attending prior to her retirement at the end of the month. He wished to record his and the Committee's appreciation of the open and helpful way Mrs Hawkins had communicated and supported the Quality and Performance Committee and her willingness to respond positively to members' questions and concerns. He wished her very best wishes for a long and healthy retirement. Mrs Hawkins thanked members for their kind comments.

NOTED

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

There was submitted a paper [Paper No: 14/42] 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).

As at 10 March 2014, 155 weeks of the 201 week contract had been completed and the project remained within timescale and budget. Contract completion was now 26 January 2015 and Mr Loudon provided members with images in a presentation highlighting the progress of both the adult and children's hospitals.

The Project Team input to the design of the new hospitals was now minimal. The latest drawings to be reviewed and approved included the nurse call layouts for the inpatient wards, and fixtures and fittings for the adult atrium and restaurant areas.

Mr Loudon highlighted progress within the new adult acute hospital, new children's hospital and the internal fit-out/inspection process.

Car Park 1 would be completed by the end of July 2014. However, following review of the car parking strategy for the site, it had been decided that there was limited benefit for the Board to negotiate a beneficial occupancy at present and it would be handed over to the NHS Board on the completion of both hospitals by 26 January 2015.

Mr Loudon also highlighted that the NHS Board had entered into dialogue with Brookfield Multiplex about the link bridge from the adult hospital to the Institute of Neurosciences building. The current design was considered to be austere and detracted from the high standards of design evident from the adult hospital and would also impact on the new Teaching and Learning Centre and new office block.

Options had been discussed to revise the design and install an aesthetically acceptable solution and add value by also enhancing the operational functionality of the link bridge. In addition, the Board was considering a Capital Project to enhance the main entrance of the Institute of Neurosciences with the objective of optimising the use of space to create a sense of arrival on entering this building. Currie and Brown UK Ltd had been commissioned to prepare a report on the procurement options. The intention was that the Board consider and implement a negotiated procurement route with Brookfield Multiplex and follow the steps noted within the paper to demonstrate value for money. The requirement would be to complete both sets of work during the financial year 2014-15 and the preservation of a single warranty for all works associated with the installed link bridge and any amendments to incorporate the new Neurosciences entrance.

Mr Loudon then took members through the progress in relation to the Energy Centre, Teaching and Learning Centre, Clinical Research Facility and the new staff accommodation (office) building.

Mr Robertson highlighted that some Non-Executive Members had been able to visit the new hospitals last Friday and a further visit had been arranged for the following Friday. Six members had confirmed their attendance and if the other members wished to attend, they should let Mr Loudon know as soon as possible.

In response to a question from Mr Winter, Mr Loudon advised that the technical inspections as a result of the pending expiry of the two year defects liability period for the new laboratory at the Southern General Hospital related mainly to minor issues of fixing cracked mirrors in toilet areas and other such works.

DECIDED

- That, the progress report on the New South Glasgow Hospitals Development be noted.

- That, the negotiated procurement route with Brookfield Multiplex for the Neurosciences entrance and new link bridge be approved on the basis of the works being completed in the financial year 2014-15 and reserving a single warranty for all works associated with the installed link bridge and any amendments to incorporate the new Neurosciences entrance. **Project Director**

50. CAPITAL PLANNING AND PROPERTY COMMITTEE GROUP MINUTES – MEETINGS HELD ON 17 DECEMBER 2013 AND 24 JANUARY 2014

There was submitted a paper [Paper No: 14/43] enclosing the minutes of the Capital Planning and Property Group meetings of 17 December 2013 and 24 January 2014.

NOTED

51. DATE OF NEXT MEETING

9.00am on Tuesday 20 May 2014 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12:40pm

ACTION BY