

DRAFT

QPC(M)14/03
Minutes: 52 - 84

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 20 May 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	Mr I Fraser
Ms M Brown	Cllr J McIlwee
Dr H Cameron	Mr D Sime
Cllr M Cunning (To Minute 79)	Mr B Williamson
Mr P Daniels OBE	Mr K Winter

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

Dr J Armstrong	Mr R Finnie (To Minute 78)
Mr R Calderwood	Cllr M MacMillan
Dr L De Caestecker	Mr A O Robertson OBE

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

Mr G Archibald	.. Interim Lead Director, Acute Services
Ms A Baxendale	.. Head of Health Improvement and Inequalities (For Minute 68)
Ms L Carroll	.. Programme Manager – HIV/STIs (For Minutes 71a, 71b)
Mr A Crawford	.. Head of Clinical Governance (For Minute 69)
Mr A Curran	.. Head of Capital Planning and Procurement (For Minute 81)
Mr A Daly	.. Head of Financial Planning and Allocations (For Minute 81)
Ms J Erdman	.. Corporate Inequalities Team Manager (For Minutes 71a, 71b)
Mr J C Hamilton	.. Head of Board Administration
Mr D Leese	.. Director, Renfrewshire CHP (For Minute 70)
Mr D Loudon	.. Project Director - South Glasgow Hospitals Development
Mr A McCubbin	.. Head of Finance – Capital and Planning (For Minute 58)
Mr A MacKenzie	.. Interim Director, Glasgow City CHP
Ms T Mullen	.. Acting Head of Performance and Corporate Reporting
Mr I Reid	.. Director of Human Resources
Ms C Renfrew	.. Director of Corporate Planning and Policy
Mr D Ross	.. Director, Currie & Brown UK Limited (For Minute 80)
Ms H Russell	.. Audit Scotland

52. APOLOGIES

Apologies for absence were intimated on behalf of Councillor A Lafferty and Ms R Micklem.

53. DECLARATIONS OF INTEREST

Declarations of interest were raised by two NHS Board Members in relation to items included in the agenda for this meeting:-

1. Mr R Finnie – Agenda Item 17 – NHSGGC: Food Retail Policy

Mr Finnie is a Trustee with the charity – League of Hospital Friends, Inverclyde.

2. Councillor M MacMillan – Agenda Item 19 – Proposal for Elderly Mental Health Continuing Care Beds

Councillor MacMillan is the leader of Renfrewshire Council.

54. MINUTES OF PREVIOUS MEETING

On the motion of Councillor J McIlwee and seconded by Mr B Williamson, the Minutes of the Quality and Performance Committee Meeting held on 18 March 2014 [QPC(M)14/02] were approved as a correct record.

55. MATTERS ARISING

(a) Rolling Action List

NOTED

(b) NHSGGC Access Policy – EQIA Action Plan - Update

There was submitted a paper [Paper No: 14/45] by the Interim Lead Director, Acute Services providing an update on the Access Policy EQIA Action Plan and setting out the progress on all outstanding actions.

Mr Archibald indicated from the Action Plan that those areas shaded grey had been completed and those unshaded actions were still ongoing. The “did not attend” rate was still being regularly reviewed as, although there had been a 1% improvement, the NHS Board’s position was still higher than the Scottish average. In addition, Mr Archibald drew attention to the measures being put in place to ensure referrers of patients with additional support needs were providing details of this to secondary care to ensure equitable access and a National Short Life Working Group was currently progressing a proposal to use the SCI Gateway to transfer patient information on additional needs. In the interim, work was ongoing locally with the Inequalities Team and GPs to identify a way for patients’ additional needs to be more prominently highlighted within referral letters.

**Interim Lead
Director, Acute
Services**

In addition, Mr Archibald reported on the analysis undertaken of patient waiting time trends which was carried out to ensure that the implementation of the Access Policy had not led to any unforeseen bias to any particular patient group. In particular, it was to ascertain if the implementation of the Access Policy had had any detrimental impact on patients living in more deprived areas of the Board. The paper indicated

that the average waiting time totals for the whole year for each Scottish Index of Multiple Deprivation (SIMD) quintile were all between 27 and 28 days. Average waiting times for each month fluctuated across the year between 25 and 29 days with each quintile subject to some variation. It was however, being recommended that the following data were analysed:-

- Average waiting time at a specialty level;
- Average waiting time for each hospital site;
- Waiting times categorised by other protected characteristics;
- Outpatient data.

Mr Williamson welcomed this report and its findings and asked if the issue of unavailability had been considered. Mr Archibald intimated that the whole patient journey had been looked at and a specific focus on unavailability across the SIMD categories would be possible. He would include outpatients and, as notified earlier, the “did not attend” rates.

Mr Calderwood emphasised the benefits of the Board’s Access Policy and the analysis undertaken showed that equitable access was available across all five SIMD categories. The whole patient journey incorporating the access to cancer care particularly for those within the deprived categories was acknowledged to be part of the further review.

**Interim Lead
Director, Acute
Services**

NOTED

56. YEAR END UPDATE

In the absence of the Director of Finance who was attending the Scottish Parliament Health and Sport Committee, the Chief Executive advised that subject to the full auditing process for the Annual Accounts 2013-14, the year-end position was as had been forecast in the Director of Finance’s monitoring reports to the NHS Board and Quality and Performance Committee. The draft Annual Accounts following the full audit process would be submitted to the Audit Committee in June and to the NHS Board on 24 June 2014 for approval.

NOTED

57. 2014/15 DRAFT FINANCIAL PLAN

There was submitted a paper [Paper No: 14/46] by the Director of Finance providing members with an overview of the key elements within the Financial Plan, highlighting key assumptions and risks and explaining how it was proposed to address the cost savings challenge which the Board faced in order to achieve a balanced financial outturn in 2014/15. The Committee was being asked to scrutinise the Board’s 2014/15 Financial Plan and recommend it for formal approval by the NHS Board at its meeting on 24 June 2014.

Mr Calderwood presented the Financial Plan to members. He highlighted the need to improve performance with waiting times at Accident and Emergency Departments; the changes in relation to the Change Fund; the non-recurrent monies set aside for next winter and the additional contributions required for the Clinical

Negligence and Other Risk Insurance Scheme (the National Risk Sharing Scheme for the settlement of legal claims).

Ms Brown highlighted members' comments at the Away Day and the recent Board Seminar that any review of services should protect resources currently targeted at those in greatest need and subjected to poverty within the NHS Board area. It should not be the case that the Board's actions should make matters worse in health terms for those most vulnerable within our society. Mr Calderwood intimated that he had emphasised this point when he met individually the CH(C)P Directors when discussing the 2014/15 Financial Plan.

Mr Winter sought further information on how it was intended to address the risks which had been clearly set out within the paper. He was concerned at the movement in bed numbers, impact on wards and the need to seek further savings from procurement. Mr Calderwood indicated that the paper set out the known risks which had been identified at the time of drawing together the Financial Plan. A contingency fund had been set aside and whilst it would always be desirable to have a large contingency, it was not thought prudent to seek a further reduction in services to ensure a more significant contingency fund. Turning to the specifics, Mr Calderwood indicated that the bed model was phased across all the hospital sites. In addition it was the case that there were currently almost 300 beds within NHSGGC which were occupied by elderly patients who had been assessed as fit for discharge but whose arrangements were still being organised for their individual placements within appropriate care settings. In relation to procurement, there was a continuation of the product rationalisation programme through aggregating procurement to a smaller set of suppliers. This programme to date had proven particularly successful in reducing unnecessary costs. The Financial Plan had been worked up with Board Members at the Away Day and NHS Board Seminar and he believed it set out sensible recommendations for seeking a balanced budget for 2014/15, recognising the additional pressures which would be faced in the two financial years thereafter.

Mr Finnie recognised the disconnect between the known risks and setting the Contingency Fund of £5m. He was not able to find coherence from the Financial Plan, Capital Plan to the delivery of the necessary HEAT and local targets. Members recognised the need to set a balanced budget for the year and the difficulties in doing this with a number of imponderables, and emphasised the need to ensure regular and detailed monitoring took place throughout the financial year in order to be able to respond to any changing circumstances.

It was also recognised that in submitting the paper to the June NHS Board meeting, it would be useful to set out a fuller description of the risks identified within the paper and steps which could be taken to minimise their impact.

DECIDED

- That, subject to a fuller description of the risks and steps to minimise these, that the NHS Board's 2014/15 Financial Plan be submitted to the June NHS Board meeting with the recommendation that it be approved.

**Director of
Finance**

58. PROPOSED CAPITAL PLAN 2014/15 TO 2016/17

There was submitted a paper [Paper No: 14/47] by the Director of Finance setting out the proposed allocation of capital funds for 2014/15, indicative allocations for 2015/16 and 2016/17 and the request to delegate to the Capital Planning and

Property Group the authority to allocate any additional available funds against the 2014/15 Capital Plan throughout the year.

Mr Calderwood took members through the Capital Plan and advised that the adjusted sum for capital resources for 2014/15 was £179.520m, of which £121.867m was committed to the new Southside Hospitals Development. Mr Calderwood also highlighted the schemes associated with the Adult Mental Health Services, radiotherapy equipment replacement, PET scanner replacement, carbon reduction programme and the HUB Initiative in relation to the construction of health centres in the next two years.

Mr Finnie enquired about the coherence between the energy spend and link to the HEAT target for carbon reduction. Mr Calderwood indicated that in relation to carbon reduction, the largest reduction would be in opening and moving to the new Southside Hospitals with the subsequent closures of the Western Infirmary, Victoria Infirmary, Mansionhouse Unit and Royal Hospital for Sick Children. He was also seeking a number of demolitions of redundant buildings. He highlighted the anomaly in the calculation of this target highlighting the joint working with Renfrewshire Council in establishing the new Renfrew Health and Social Care Centre, the NHS Board's footprint went up as it owned the site and, despite being a joint partner in this venture, Renfrewshire Council's footprint went down as it did not own the premises.

DECIDED

- That, the proposed allocation of capital funds for 2014/15 be approved.
- That, the current indicative allocations for 2015/16 and 2016/17 be noted.
- That, the Capital Planning and Property Group be delegated the authority to allocate any additional available funds against the 2014/15 Capital Plan throughout the year.

59. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No: 14/48] by the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGGC's performance. Of the 47 measures which had been assigned a performance status based on their variations from trajectory and/or targets, 32 were assessed as green; four as amber (performance within 5% of trajectory) and eleven as red (performance 5% outwith meeting trajectory).

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

- Freedom of Information requests had moved from amber to green;
- Overtime usage had moved from amber to green;
- Complaints responded to within 20 working days had moved from amber to green;
- Carbon emissions had moved from green to red;
- Energy consumption had moved from green to red.

Exception reports had been provided to members on the eleven measures which had been assessed as red and this had included new exception reports for carbon emissions and energy efficiency. Performance relating to the early detection of cancer and the IVF HEAT targets had been included in the integrated report for the first time. Lastly, the report highlighted three legal cases in 2013 which were reported on by the Equality and Human Rights Commission which provided clarity in disability discrimination claims. The clarification directly related to the NHS Board's "Release Potential" campaign where the NHS Board wished to promote an environment where staff members felt able to tell their managers about their disability and where managers understood the benefits of developing a workplace culture which was supportive to disabled people.

In relation to a question from Ms Brown about seeking more information on cancer times and in particular, the glaucoma service within ophthalmology, Mr Archibald indicated that steps were being taken to redesign this service as it continued to be very disappointing that patients were breaching their waiting time guarantees within this sub-specialty area. He was aware that performance remained good around meeting the 31 day target for access to cancer services however, there had been a deterioration in meeting the 62 day target. He agreed that he would bring a further paper to the next meeting of the Committee highlighting the difficulties and the steps being taken to make improvements to this important service area.

DECIDED

- That, the May 2014 Integrated Quality and Performance Report be noted.
- That, a paper be submitted to the next meeting of the Committee on the steps being taken to improve cancer waiting times and, in particular, the glaucoma service within ophthalmology.

**Interim Lead
Director, Acute
Services**

60. SCOTTISH PATIENT SAFETY PROGRAMME: UPDATE

There was submitted a paper [Paper No: 14/49] by the Medical Director, which provided a review of the Maternal and Child Quality Improvement Collaborative which consisted of the paediatric, maternity and neonatal workstreams together with a report on the recent review visit by Healthcare Improvement Scotland and the National Clinical Lead for Safety.

The paper highlighted that the Acute Services Division had made good progress in relation to the Paediatric workstreams. The Women's and Children's Directorate had recently revised the structures in place to support the Maternal and Child Quality Improvement Collaborative in order to align it to the new collaborative arrangements within the SPSP monitoring groups established for both obstetrics and gynaecology and hospital paediatrics and neonatology.

Members welcomed the write-up of the review visit from Healthcare Improvement Scotland and National Clinical Lead for Safety and it was noted that the outline of the NHS Board's approach and progress had been well received.

NOTED

61. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No: 14/50] 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 was that the recent validated results for quarter 4 confirmed a total of 133 SAB cases between October and December 2013. This equated to a SAB rate of 36.8 cases per 100,000 acute occupied bed days (AOBDs). As indicated at the last meeting however, the local data for 2014 quarter 1 indicated a 26% reduction in case numbers, equating to an estimated rate of 28.2 cases per 100,000 AOBDs. The validated results for quarter 1 were expected to be published in July 2014.

In addition, Dr Armstrong highlighted that there had been a significant increase in orthopaedic surgical site infections at the Royal Alexandra Hospital between November 2013 and February 2014. Meetings had been held with the clinical team and a number of actions had been taken in reviewing the patient risk factor pathways. These actions remained ongoing, however, it was known that there had only been one surgical site infection in orthopaedics in April 2014, although the situation continued to be closely monitored.

NOTED**62. CLINICAL RISK MANAGEMENT REPORT: SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS AND FAIs**

There was submitted a paper [Paper No: 14/51] by the Medical Director on the handling of adverse clinical incidents together with an update on the current fatal accident enquiries. The paper highlighted that there had been one episode of wrong site surgery (procedure performed on wrong body part) when the site changed from that which was planned after the patient was positioned on the table and imaging reviewed. An investigation was currently underway in relation to this case. There had also been two wrong site blocks (local anaesthetic performed on wrong body part) and both these events were still under investigation although it did appear in both cases that the “stop before you block” process had not been properly implemented. These events had been discussed at the Theatres and Anaesthetics Clinical Governance meeting, and greater awareness of these events had been raised in all departments.

There had been five medication errors which fell into the category of avoiding serious events monitoring, and all were currently under investigation. Lastly, there had also been 39 pressure ulcers reported as developing since the last report and discussions were ongoing with the Tissue Viability Service in relation to improving the quality of this data and providing an indication of avoidability and it was hoped to have the revised dataset for the next report.

**Medical
Director**

Dr Armstrong highlighted the Sheriff’s determination in relation to Ms McC and the improvements that had been put in place since 2008, including the increased hours of consultant presence, a modified early warning system now in place, and the notification of the on-call Consultant Obstetrician when any patient was admitted to the obstetric high-dependency unit or equivalent unit. Further discussions were underway in relation to access to medical/surgical opinions in such cases and the timescales in which they should be obtained. In response to a

member's question, Dr Armstrong indicated that the Sheriff's determination had highlighted that access to more senior medical staff and a cardiologist could have made a difference in this case.

NOTED

63. NHSGGC PAGING SYSTEM OVERVIEW

There was submitted a paper [Paper No: 14/52] by the Interim Lead Director, Acute Services providing the context and current position within the NHS Board area in relation to the paging system in operation within hospitals.

The hospital paging systems are provided by Multitone Electronics and are privately networked dedicated radio-based systems, licensed by OFCOM, which are used to deliver real-time voice and data messaging. Each site had its own autonomous local paging network which was operated either from the contact centres (in Hillington Industrial Estate and the Royal Alexandra Hospital) or on site. There had, in the past, been some instances with coverage blackspots on the paging system and these had been addressed at the time, and the paper highlighted specific issues and resolutions. Since the move to the Hillington contact centre, the emergency paging group was tested on a daily basis and this has not identified any issues with blackspots on the current sites.

Members welcomed this report and asked Mr Archibald if specific information could be provided on the incident which highlighted the need to review the paging system and also the rationale behind the number of pagers used on different hospital sites.

DECIDED

- That, the paper setting out the current position in relation to the paging system within NHSGGC be noted.
- That, a further paper be provided which covered the specific incident which had led to the need to review the paging system and an explanation as to the rationale of pagers across different hospital sites.

**Interim Lead
Director, Acute
Services**

64. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 14 APRIL 2014

There was submitted a paper [Paper No: 14/53] enclosing the minutes of the Board Clinical Governance Forum meeting held on 14 April 2014.

NOTED

65. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN: 1 JANUARY – 31 MARCH 2014

There was submitted a paper [Paper No: 14/54] 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 two investigation reports for GPs and 21 decision letters relating to ten within Acute Services, five

within Partnerships and six within Family Health Services. The Ombudsman investigated total of 32 issues, twelve of which were upheld and 20 not upheld and the Ombudsman had issued 31 recommendations.

NOTED

66. PLANNING FOR THE COMMONWEALTH GAMES

There was submitted a paper [Paper No: 14/55] by the Director of Public Health asking members to note the planning being undertaken in preparation for the Glasgow Commonwealth Games 2014.

The NHS Board Civil Contingencies Planning Unit had been extensively involved in the preparations for the Games with the Commonwealth Games Organising Committee (Medical Services, Transport Services, Food Safety, Safety and Security), Scottish Government, NHS Resilience Team, Police, Ambulance Service, Local Authorities and Health Protection Scotland. In addition, 14 clinical expert groups had been formed to assist the Organising Committee Medical Services in the planning for medical provision and eleven Task and Finish Groups had been formed to lead the planning at NHS Scotland level coordinated through the NHS Resilience Team.

NHSGGC would continue to deliver services as usual to its resident population during the Games and internal planning had been led by the Civil Contingencies Strategic Group with three identified workstreams, namely; health protection, health services and health resilience.

Police Scotland were responsible for the overall safety and security and they have worked with the full range of partners including the NHS Board. Discussions were ongoing regarding the awareness and management of “fixated people” with both Police Scotland and the Fixated Threat Assessment Centre in London. A mass casualty tabletop exercise had recently been undertaken to test the NHS Board’s Strategic Major Incident Plan and a further exercise was held last week to test the daily routine of operation during the Games.

NOTED

67. HEALTH PROMOTING HEALTH SERVICE (CEL 01 2012) ANNUAL REPORT

There was submitted a paper [Paper No: 14/56] by the Director of Public Health asking the Committee to formally ratify the Year 2 submission and continue to support the implementation of the Health Improvement programmes in hospital settings. This initiative aimed to build on the concept that every healthcare contact was a health improvement opportunity, recognising the important contribution that hospitals can make to promoting health and enabling wellbeing in patients, families, visitors and staff.

NHS Boards were required to carry out actions in relation to underpinning and enabling activity to support health improvement in the hospital setting as well as the delivery of specific topic-based actions with defined performance measures. The Board was able to evidence significant progress in relation to all actions in Year 2. The submission had been sent to SGHD within the timescales set however, if any amendments were necessary as a result of discussions with members, these

would be notified to SGHD.

Members welcomed the steps being taken thus far and the actions highlighted for Year 3 and it was noted that Rev Dr Norman Shanks, Non-Executive Member, was the Lead Non-Executive Director for this issue with Ms Morag Brown leading on Staff Health. Dr Cameron highlighted an error in the percentage of Allied Health Professionals in one of the tables and it was agreed that this would be altered and SGHD notified.

DECIDED

- That, the Year 2 submission to SGHD be approved, subject to the alteration highlighted by Dr Cameron.

**Director of
Public Health**

68. NHSGGC FOOD RETAIL POLICY

There was submitted a paper [Paper No: 14/57] by the Director of Public Health asking members to consider the Food Retail Policy and recommend its approval by the NHS Board.

The NHS Board first endorsed a policy position on food, fluid and nutrition in 1993 and the extant Food, Fluid and Nutrition Policy was approved in 2008 with a subsequent review in 2011. The key objective of the policy was to increase availability of an acceptable and appropriate healthy diet for employees, visitors and outpatients within NHSGGC. NHSGGC operated dining, cafe and vending facilities and had successfully achieved a high level of compliance with national and local healthy eating guidance. This included:-

- 12 Aroma Cafes/ten dining rooms with Health Living Award +
- One Aroma Cafe/two dining rooms with Healthy Living Awards
- 60 drink vending machines – 100% sugar free
- 34 snack vending machines with 50% healthier items
- 8 meal vending machines with Healthy Living Awards

The Aroma Cafe brand was a wholly owned NHS coffee bar brand piloted within NHSGGC and now extended to 16 outlets across NHS Scotland, all meeting the Health Living Award + status. The last four years had seen income generation reduce a NHSGGC retail deficit into a £73,000 surplus in 2013/14.

The Food Retail Policy proposed that NHSGGC adopted an exemplar position in the routine provision of healthy eating opportunities for patients, staff and visitors. The remaining vending machines, managed by external companies, were now moving towards compliance with the Food Retail Policy. In addition, on completion of the move to the New Southside Hospitals in 2015, at least 16 lease agreements with externally operated retail shops, cafes, tea rooms and trolleys were anticipated to be in operation.

In response to Councillor Cunning's comments about healthy eating within schools, Dr de Caestecker advised that the standards within hospitals were not as stringent as within schools and this was in an attempt to ensure people were given healthy choices rather than attempt to stop them leaving the site and possibly opting for unhealthy choices. The policy sought outlets and shops providing 70% compliance with sugar free drinks or a limited range of sugar based drinks and this was not set at 100% for medical and nutritional reasons, particularly around nutritionally vulnerable or mental health patients accessing sugar based drinks. In relation to

nutritional composition and content, concern was raised that the levels of fats and oils must be kept to a minimum and that this was not specific enough. Ms Baxendale advised that specific requirements were set as part of the national criteria and the detail was contained within the National standard documents referenced in the policy.

DECIDED

- That, the Food Retail Policy be approved and the NHS Board be recommended to adopt the policy at its next meeting.

**Director of
Public Health**

69. NATIONAL PERSON-CENTRED HEALTH AND CARE COLLABORATIVE: STRATEGIC WORK PLAN AND REPORT

There was submitted a paper [Paper No: 14/58] 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 information on the second Person-Centred Health and Care local learning session held on 25 March 2014; the fourth national learning session for the Person-Centred Health and Care Collaborative on 27 and 28 May 2014 at the SECC, Glasgow and also a brief summary of the informal visit by Ms Ros Micklem, Non-Executive Member of the Board.

The local learning session on 25 March had received encouraging feedback and it was hoped to hold a third learning session in late August/early September 2014 which would concentrate on staff wellbeing, resilience and their relationship to effective care. The national learning session on 27 and 28 May would include the Minister for Public Health and the Divisional Clinical Lead, Quality Unit, SGHD. In addition, a number of staff from NHSGGC would be presenting at this event.

Members welcomed the report and its comprehensive nature and helpful case studies, and Ms Brown asked that Section 3 be written in such a way that it was more relevant and accessible to patients.

Nurse Director

NOTED

70. PROPOSAL FOR ELDERLY MENTAL HEALTH CONTINUING CARE BEDS

There was submitted a paper [Paper No: 14/59] from the Director, Renfrewshire CHP providing information to the Committee on the proposals for the relocation of the Renfrewshire Elderly Mental Health Continuing Care patients and the location of the Adult Physically Disabled Beds, currently located at the Southern General Hospital site.

Mr Leese explained that, in 2012, due to issues related to asbestos and fire compartmentation, the two Elderly Mentally Ill Continuing Care wards had been temporarily relocated from Dykebar Hospital to the Mansionhouse Unit in South East Glasgow. Having established that these wards could not return to Dykebar Hospital, work had been taken forward to consider options for the future location of these 48 beds. Alongside this, the Renfrewshire Ten Year Joint Strategic Commissioning Plan for Older People had been in development and was now at an advanced stage and outlined a clear vision where services and stakeholders would

work in partnership with older people, carers, families and communities to support living at home or in a more homely setting for as long as possible.

As part of this wider work, Renfrewshire Council had identified that the current model of residential care provision it offered was not sustainable and the Council's Social Work, Health and Wellbeing Policy Board on 6 May 2014 agreed that the Director of Social Work should proceed to develop an option to reduce the number of Council residential homes from three to two. This could possibly lead to the transfer of Hunterhill Care Nursing Home to the NHS Board through a lease of the building. The facility had capacity for 60 beds and offered single room, en-suite accommodation and had excellent internal and external space for the benefit of patient care.

In relation to the Adult Physical Disability NHS Continuing Care Service, this was currently provided within ward 53 in the Langlands Building, located in the Southern General Hospital. This ward provided a mix of multiple bed base and single room layouts. The single room layout was the preferred layout for NHS Continuing Care.

Councillor MacMillan recognised the ongoing partnership work to date and indicated that he was ensuring that proper and meaningful consultation would be taken forward on the issue of residential home provision. He had spoken with the relatives and was aware that there was a genuine concern and a lack of trust and that trust required to be rebuilt. The original plan had been that a submission would be made to the Council's Social Work, Health and Wellbeing Policy Board in August but this would now be put back to October 2014 and the consultation process would be extended and more intense than first mooted by the Social Work Department. No final decision had been taken by Renfrewshire Council and the Council would listen to advice from the NHS, other professionals and the relatives and other representatives of the patients. He felt that it was particularly important to build trust for what should be seen as a service improvement for patients.

Mr Robertson thanked Councillor MacMillan for his comments and was encouraged by the continuation of the joint working between the NHS Board and the Council in this area. He was aware that a number of NHS Board members had received email messages from concerned relatives and Mr Leese indicated that, as a result of today's meeting, he would be responding to these messages. Mr Fraser said that he had also been contacted by relatives and had read the local media reports and felt it was a credit to Councillor MacMillan that he had met the relatives individually in order to understand their concerns.

**Director,
Renfrewshire
CHP**

Mr Calderwood indicated that if Renfrewshire Council proceeded with its plans to move from three to two residential care homes and the publicly funded Hunterhill Care Home became available for lease, the NHS Board would be interested. The NHS Board would await the outcome of the process being undertaken by Renfrewshire Council and once a decision had been taken one way or the other, the Board would then consider its position. If Hunterhill Care Home did not become available there would be a need to submit a separate paper to the NHS Board with the options available at that time.

Ms Brown stressed her concern that it was important not to compromise the appropriate care of the young physically disabled patients. Her concerns related to whether the possible move was based on a strategic decision based on a strategy for young physically disabled patients or if it was a convenient arrangement. She was concerned that such a move may not take account of that patient group's views, the views of agencies in that area or any independent views of what was best for the

patients. Mr Calderwood indicated that the young physically disabled patients within the Langlands Unit at the Southern General were not all located within single rooms and the NHS Board had been committed to providing alternative suitable accommodation for them by the summer of 2015. Ms Renfrew indicated that a commitment had been given to improve the services for these patients but as it was a small group of patients, it was not a decision based on a current strategy but a need to ensure suitable accommodation for this important patient group and to ensure that they were not cohabitating with other patient groups.

Mr Williamson described the helpful discussion within Renfrewshire CHP and while recognising that this would be a service improvement and a more convenient location for patients temporarily located within the Mansionhouse Unit, there was a lot of work to assist the relatives in understanding the advantages in the moves proposed for their loved ones. It was highlighted that the three residential care homes within Renfrewshire were operating at a 60% occupancy level. Mr Daniels sought confirmation that the NHS Board's Capital Plan had set aside £250,000 for this issue within Renfrewshire and Mr Calderwood agreed that this was indeed the case. He went on to say that there did require to be a Board level debate about the young physically disabled patients to ensure the appropriate specialist nursing care and clinical staff were available for this patient group within an appropriate setting.

NOTED

71. TACKLING INEQUALITY

(a) MEETING THE REQUIREMENTS OF EQUALITY LEGISLATION – A FAIRER NHSGGC: MONITORING REPORT 2013-14

There was submitted a paper [Paper No: 14/60] by the Director of Corporate Planning and Policy describing how the NHS Board currently met and would continue to meet the requirements of the public sector equality duty. All public sector organisations are required to comply with the Equality Act 2010 and this Act established the public sector general equality duty which required organisations in the course of their day-to-day business to eliminate discrimination, harassment, victimisation, advanced equality of opportunity between persons who share a relevant characteristic and persons who do not, and foster good relations between people who shared protected characteristics and those who do not.

The characteristics referred to in the Equality Act 2010 have been identified as age, disability, sex, gender reassignment, pregnancy and maternity, race and ethnicity, religion and belief, sexual orientation and marriage and civil partnership.

There was a requirement to provide a monitoring report every two years on the activities in relation to the equality strategy, however NHSGGC had been doing this annually since the inception of the Act.

Dr Benton highlighted that one of the key findings was a noticeably larger percentage of respondents who reported having some form of disability than had been identified through routine staff collection (21.6% of 861 respondents as opposed to 0.5% of staff equality monitoring data). Ms Erdman acknowledged this and indicated that the "Release Potential" campaign was being targeted at staff and it was hoped it would also lead to additional confidence in staff reporting on disability. Meetings would be

held with staff under this campaign to get their views on these important issues. Ms Brown thanked Ms Erdman and her staff for this helpful report and encouraged continued vigilance in this area.

DECIDED

- To publish the report to staff and the public.

**Director of
Corporate
Planning and
Policy**

(b) DEVELOPING A SYSTEMATIC APPROACH TO TACKLING INEQUALITY: ACTION TO CLOSE THE GAP IN HEALTH OUTCOMES

There was submitted a paper [Paper No: 14/61] by the Director of Corporate Planning and Policy and the Director of Public Health seeking approval to the approach outlined in the paper to identify and close the gap in health outcomes caused by poverty and other vulnerability. At the March Quality and Performance Committee meeting, a paper was considered on the progress in reducing inequalities and the gap in health caused by poverty as part of the NHS Board's aspiration to develop a systematic approach to tackling health inequality. This paper developed that work into more detailed proposals and future reporting to the Committee would consider specific areas where there was a gap in health outcomes as a consequence of poverty and interventions being undertaken to address this. These areas would include antenatal care, prisoners, homelessness, looked after and accommodated children and welfare reform. In addition, steps would continue to be taken to improve the collection of disaggregated data by SMID and protected characteristics and set explicit targets to measure progress.

Dr Armstrong asked about the possible links to health information/safe havens and Dr de Caestecker indicated that this would be helpful. Ms Brown asked whether this could include an action around how we developed strategies and this was acknowledged and agreed. Dr Benton welcomed the fact that work was beginning with 45 GP practices across the Board's area to address the health inequalities gap in bowel screening uptake by people with learning disability and requested an update on this work at a future meeting.

**Director of
Public Health**

DECIDED

- That, the approach outlined in the paper to identify and close the gap in health outcomes caused by poverty and other vulnerabilities, be approved.
- That, an update on bowel screening for people with a learning disability come back to a future meeting.

**Director of
Public Health**

**Director of
Public Health**

72. GP OUT OF HOURS PAYMENTS

There was submitted a paper [Paper No: 14/62] by the Interim Lead Director, Acute Services seeking approval to a rise in the rate of pay for out of hours sessional GP payments over the summer period 2014 and a 1% uplift.

In 2004, NHS Boards assumed the responsibility for GP out of hours with the new

contract and there was a mixture of different models across the country with no nationally agreed contract or rate that applied to either salaried GPs or sessional GPs. Filling out of hours shifts had become increasingly problematic over the last 18 months with holiday periods becoming a particular issue. The sessional rate for GPs had not risen since 2004/5 and the Committee had been made aware of the difficulties in attracting the required number of GPs to provide out of hours services in holiday periods when neighbouring health boards were offering increased rates of pay.

The Director of Human Resources had established a short life working group to try and agree a longer term solution to the issue of recruitment retention and terms and conditions of this group of staff and others in a similar position across the NHS Board. It was acknowledged that a fundamental review of the service on a national basis would be required.

DECIDED

- That, the increased rate of pay for out of hours sessional GPs over the forthcoming summer leave period and a 1% pay uplift in line with other NHS staff be approved.

**Interim Lead
Director, Acute
Services**

73. MEDIA COVERAGE OF NHSGGC MAR/APR 2014

There was submitted a paper [Paper No: 14/63] by the Director of Corporate Communications highlighting outcomes of media activity for the period March – April 2014. The reported 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

74. ANALYSIS OF LEGAL CLAIMS – MONITORING REPORT (YEAR-END REVIEW 2013/2014)

There was submitted a paper [Paper No: 14/64] by the Head of Board Administration providing an overview of the handling and settlement of legal claims within NHSGGC as at 31 March 2013 and 31 March 2014. The paper also provided background information in relation to the role of the Central Legal Office, the Clinical Negligence and Other Risks Scheme (CNORIS) and how significant claims were handled. Mr Winter asked if future reports could highlight the costs paid via the CNORIS scheme in order to give a full understanding of the settlement of legal claim costs within NHSGGC. This was agreed and it was explained that the financial value of the settlement of legal claims has risen and this was reflected in the NHS Board's contribution the following year to the CNORIS scheme.

**Head of Board
Administration**

NOTED

75. 2013-14 ANNUAL REVIEW PROPOSALS

There was submitted a paper [Paper No: 14/65] by the Director of Corporate Planning and Policy advising members that the Scottish Government's proposals were that the NHS Board would have a Non-Ministerial 2013/14 Annual Review to be held on Tuesday 19 August 2014. For Non-Ministerial Reviews, the Chair of

the Board conducts a public meeting where the NHS Board is expected to outline progress against performance targets and identify challenges for the following year. Staff groups and patient groups should continue to have an opportunity to feed into the Annual Review process and NHS Boards were still required to produce a self assessment of the performance material to inform the review process.

Ms Renfrew indicated that the intention would be to seek a suitable hospital venue and this may require the moving of the NHS Board meeting which would be held that morning followed by the Annual Review.

**Director of
Corporate
Planning &
Policy**

NOTED

76. 2014-15 LOCAL DELIVERY PLAN – SIGN-OFF LETTER

There was submitted a paper [Paper No: 14/66] by the Director of Corporate Planning and Policy enclosing the contents of the Local Delivery Plan Sign-Off letter received from the Scottish Government.

NOTED

77. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 24 FEBRUARY 2014

There was submitted a paper [Paper No: 14/67] enclosing the minutes of the Quality Policy Development Group meeting of 24 February 2014.

NOTED

78. MANAGEMENT OF OVERDUE INCIDENTS IN DATIX

There was submitted a paper [Paper No: 14/68] by the Interim Lead Director, Acute Services setting out the current level of overdue incidents and the risks associated with overdue incidents.

If an incident has not been given final approval within 20 days after creation, Datix reported the incident as overdue. In December 2013, 76% of all open incidents were reported as overdue regardless of status and it was clear that incident managers were not maintaining incident status correctly. The high level of reported overdue incidents did not mean that incidents were not being managed, but it did mean that an important exception reporting mechanism was not working. The contributing factors to these high levels of overdue incidents related to management workload, Datix response times and misuse/misunderstanding of incident status.

The Short Life Working Group on the use of Datix had identified a number of recommendations relating to the upgrading of the Datix IT environment in order to improve response times. Firstly, the establishment of a permanent Steering Group to govern the organisation and use of Datix and define service levels to monitor Datix use; monthly reporting to track overdue incident levels within each area of the organisation distributed to management teams combined with the message on addressing the large backlog of overdue incidents and Datix module training to track corrective actions after an incident had been approved.

NOTED

79. SHADOW ARRANGEMENTS – GLASGOW JOINT INTEGRATED PARTNERSHIP

There was submitted a paper [Paper No: 14/69] by the Chief Executive and Interim Director, Glasgow City CHP, seeking approval to establish a Shadow Integration Joint Board (IJB) with Glasgow City Council on the basis of retaining the current Council and NHS CHP governance arrangements during the shadow period (unless changes are proposed by the Shadow IJB and agreed by the Board and Council) and the Shadow IJB reporting to the Council and the NHS Board for the programme of work outlined in the Partnership Agreement.

The Public Bodies (Joint Working) (Scotland Act) 2014 was passed by the Scottish Parliament on 25 February 2014 and received Royal Assent on 1 April 2014. The Act enabled the establishment of Integrated Health and Social Care Partnerships with Integrated Joint Boards and Chief Officers from April 2015.

The City Council and the NHS Board had agreed that the arrangements for Glasgow City should be developed on the basis of a body corporate model including all community health and social care services and a process was underway to recruit a Shadow Chief Officer for the new partnership. Mr Mackenzie explained that the City Council had identified eight Councillor members and the NHS Board, through the Chair, would now identify eight NHSGGC members.

Chair, NHS Board

DECIDED

- That, the proposals to establish a Shadow Integration Joint Board with Glasgow City Council set out in the paper, be approved.

Interim Director, Glasgow City CHP

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

There was submitted a paper [Paper No: 14/70] 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 12 May 2014, 163 weeks of the 201 week contract had been completed and the project remained within timescale and budget. Contract completion was 26 January 2015 and this would include the handover of the Adult and Children’s hospitals and Car Park 1.

In relation to design, the project team was focused on reviewing the wayfinding and signage proposals and no further design changes had been requested.

Mr Loudon updated members on the Group 5 equipment, transfer of equipment, progress on Car Park 1, Energy Centre and Teaching and Learning Centre. The Clinical Research Facility had been handed over on 2 May 2014 and end users had now completed the migration process with the facility anticipated to be operational on 2 June 2014. The new Staff Accommodation Office Building had commenced with a planned completion date of April 2015.

Mr Loudon let members know about the difficulties experienced with fixings

associated with the main roof following two which had failed and the contractor had redesigned and replaced all the fixings at no cost to the NHS Board. Mr Williamson asked about the imaging equipment and the fact that some of it would be 14 months old and Mr Loudon intimated that the contractor had complied with the programme of the project and the Diagnostics Directorate had been sighted on that issue and had put in place maintenance programmes for this equipment.

Mr Ross drew attention to the new compensation events and movements since the last meeting and explained that the MTHW system – site ring extension was related to the ability to connect this with the Maternity Building at a later date.

Mr Loudon then updated members on the progress on the design of the proposed new entrance to the Neurosurgical Building and Link Bridge. In relation to the Link Bridge, the contractor would design and bring about improvements to the Link Bridge at no cost to the Board. In relation to the new main entrance of the Neurosurgical Building, it was estimated that the capital cost was £4.10m and the funding sources were set out in the paper. If approved, a compensation event would enable the Board to contractually accept the proposal for the new entrance and would be subject to the contractor being able to demonstrate to the Board that the detailed design and cost-related plan delivered value for money and the contractor would be required to procure supply chain costs on an open book basis with capped overheads and profits.

DECIDED

- That, the progress report in relation to the New South Glasgow Hospital Project be noted.
- That, the new entrance to the Neurosurgical Building be approved at a cost of £4.10m subject to the conditions set out in the paper.

**Project
Director, New
South Glasgow
Hospitals**

81. SALE OF LANDS AT THE FORMER LENNOX CASTLE HOSPITAL

There was submitted a paper [Paper No: 14/71] by the Chief Executive providing information on the disposal of lands at the former Lennox Castle Hospital following the Secretary of State's approval of the closure of the hospital in 1998. At that time the Lennox Castle Task Force was established to assist and reduce the impact of the hospital closure in the local community of Lennoxtown.

The Task Force completed its work in 2002 following the closure of Lennox Castle Hospital however it was clear to the partnership agencies, East Dunbartonshire Council, Scottish Enterprise and the then Primary Care NHS Trust that the regeneration of Lennoxtown would be a long-term process and this led to the formation of the Lennoxtown Initiative which was set up to lead the regeneration process with a commitment that the net proceeds from the disposal of the former hospital site would be made available to the Lennoxtown Initiative for the delivery of the regeneration package.

The then Primary Care NHS Trust explored the potential development opportunities for the site with limited success on the basis of the planning constraints. However an approach by McTaggart & Mickel, the developer who owned the adjacent site at Hole Farm, presented the NHS Trust with a unique opportunity to unlock the potential for the hospital site to be developed for residential use by combining the substantial land holdings and viewing them as a single entity. Discussions between the Council and Lennoxtown Initiative resulted

in agreement that the lower site could be developed for residential use, however the upper site could only be developed for greenbelt-compatible leisure use.

The paper set out the plans and proposals however as a result of the change in market conditions within the housing market, only Plot 1a had been developed by McTaggart & Mickel and Phase 1b had been marketed with offers received but no acceptable deal was able to be struck. McTaggart & Mickel had carried out all the necessary infrastructure work for all five sites at a total cost of £7.6m with NHSGGC being responsible for 50% of that cost. Initially, the recovery of this outstanding cost was provided for by the sale of the five tranches of land however, as these did not proceed, that cost remained outstanding.

McTaggart & Mickel recently appointed a company to produce a marketing strategy report for the site and although the market for developing land was improving, the improvement in secondary market areas such as Lennox town, was still lagging behind therefore their recommended marketing plan for the four remaining phases would be:-

- Phase 1b - March 2015
- Phase 2 – March 2017
- Phase 3 – May 2018
- Phase 4 – May 2020

The marketing strategy advice was that Lennox town would not be able to sustain two housebuilders at the same time so further sites would be marketed in line with sales coming to an end on the previous phase thus only one builder developing at any one time. The NHS Board and their advisors had met with McTaggart & Mickel to discuss different options and to try and finalise the terms and conditions of the marketing strategy. The terms of the Joint Venture Agreement offered a right of pre-emption to the purchase of the sites to McTaggart & Mickel only after they had been tested on the open market and they then matched the highest offer obtained. McTaggart & Mickel however, do not have the development at the former Lennox Castle Hospital site in their three year housebuilding programme although they have expressed an interest in possibly reconfiguring that programme to include potential development in the financial year 2016/17.

In relation to the upper site which was to be greenbelt-compatible, this site had a minimal forecasted capital receipt with any receipts generated accruing to the Lennox town Initiative.

Celtic PLC, in November 2004, sought to purchase the upper site for use as a sports academy i.e. a sports and training facility and this was regarded as greenbelt-compatible use and seen as a positive step towards the objective of achieving a fully developed former hospital site. The sale was completed with Celtic PLC at the sum of £493,000 which was in excess of the independent valuation of £480,000. The land was not sold on the open market however was sold off-market in accordance of Part B, Clause 1.15 of the NHS Scotland Property Transactions Handbook, achieving the best possible receipt. If Celtic PLC choose to submit planning consent for use outwith the permitted use as a sports academy, Scottish Ministers were protected by a significant claw back agreement over a 25 year period. Mr Calderwood advised members that this particular transaction had been subjected to a number of Freedom of Information requests and the NHS Board had made available all relevant paperwork on its website.

DECIDED

- That, the position regarding the outstanding infrastructure debt be noted.
- That, the proposal to remarket the sites to realise capital receipts in a rising property market be noted.
- That, the historical position on the land sale of the upper site to Celtic PLC be noted.

82. CAPITAL PLANNING AND PROPERTY COMMITTEE GROUP MINUTES – MEETINGS HELD ON 26 MARCH AND 9 MAY 2014

There was submitted a paper [Paper No: 14/72] enclosing the minutes of the Capital Planning and Property Group meetings of 26 March and 9 May 2014.

Mr Calderwood intimated that the intention would be to bring a Property Disposal Strategy to the Quality and Performance Committee in July or September 2014.

Chief Executive

NOTED

83. ANY OTHER COMPETENT BUSINESS

- (i) Mr Calderwood reported that Mr Paul James, Director of Finance, had secured a new post at the Cambridge University Hospitals NHS Foundation Trust and would commence his new duties in mid to late August 2014. He and the members thanked Mr James for his contribution to the work of the NHS Board over the last three years and wished him well with his new responsibilities.
- (ii) Mr Lee intimated that this would be Mr Barry Williamson's last meeting of the Committee as his second term of office as a Non-Executive member of the Board ended on 30 June 2014. Mr Lee, on behalf of the Committee, thanked Mr Williamson for his contribution to the working of the Committee, particularly in and around the areas of clinical governance, scrutiny and monitoring. Mr Williamson thanked Mr Lee and members for their kind comments.

84. DATE OF NEXT MEETING

9.00am on Tuesday 1 July 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