

DRAFT

QPC(M)14/04
Minutes: 85 - 107

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 1 July 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

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|--------------------------------|---------------------|--------------------------------|
| | Mr I Lee (Convener) | |
| Dr C Benton MBE | | Cllr A Lafferty |
| Ms M Brown | | Ms R Micklem |
| Cllr M Cunning (to Minute 103) | | Cllr J McIlwee (to Minute 103) |
| Mr I Fraser | | Mr D Sime |
| | Mr K Winter | |

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

| | |
|----------------------------------|----------------------|
| Mr R Calderwood | Mr P James |
| Mr R Finnie | Mr A O Robertson OBE |
| Rev Dr N Shanks (From Minute 92) | |

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

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|-----------------|----|--|
| Mr G Archibald | .. | Interim Lead Director, Acute Services |
| Mr A Crawford | .. | Head of Clinical Governance (To Minute 92) |
| Mr J C Hamilton | .. | Head of Board Administration |
| Mr D Loudon | .. | Project Director - South Glasgow Hospitals Development (From Minute 103) |
| Mr A MacKenzie | .. | Interim Director, Glasgow City CHP (To Minute 97) |
| Mr A McLaws | .. | Director of Corporate Communications |
| Ms J Miller | .. | Service Manager for Prison Healthcare (For Minute 97) |
| Ms T Mullen | .. | Acting Head of Performance and Corporate Reporting |
| Mrs K Murray | .. | Director, East Dunbartonshire CHP |
| Mr I Reid | .. | Director of Human Resources (To Minute 103) |
| Ms C Renfrew | .. | Director of Corporate Planning and Policy (To Minute 103) |
| Mr D Ross | .. | Director, Currie & Brown UK Limited (For Minute 103) |

85. APOLOGIES

Apologies for absence were intimated on behalf of Mr P Daniels OBE and Dr H Cameron.

86. DECLARATIONS OF INTEREST

There were no declarations of interest raised.

87. MINUTES OF PREVIOUS MEETING

On the motion of Councillor McIlwee and seconded by Mr K Winter, the Minutes of the Quality and Performance Committee Meeting held on 20 May 2014 [QPC(M)14/03] were approved as a correct record.

88. MATTERS ARISING

(a) Rolling Action List

Minute 38 – Inequalities – Update on Progress

Ms Micklem enquired about the review of the template for Board and Committee papers to ensure they reflected inequalities and equalities dimensions. Ms Renfrew noted that although the current summary was considered to be adequate, it could be improved. Staff/managers required guidance to assist them in completing the template and Ms Renfrew agreed that this guidance would be drafted and shared with Members prior to implementation.

**Director of
Corporate
Planning &
Policy**

NOTED

89. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No: 14/74] by the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGGC's performance.

Of the 47 measure which had been assigned a performance status based on their variance from trajectories and/or targets, 29 were assessed as green; 9 as amber (performance with 5% of trajectory) and 9 as red (performance 5% outwith meeting trajectory).

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

- MRSA/MSSA bacterium cases per 1,000 average occupied bed days had moved from red to amber;
- Percentage of new outpatient appointments – did not attends – had moved from red to amber;
- All cancer treatments (31 days) had moved from green to amber;
- Rate of attendance at A&E had moved from green to amber;
- 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.

Mr Finnie raised aspects of the Exception Report in relation to the target to reduce energy consumption and carbon emissions. He noted that the in-year performance

to date was not achieving the required HEAT target however the paper highlighted ongoing discussions with Health Facilities Scotland and the Scottish Government around the accuracy of aspects of the original HEAT targets. Mr Calderwood agreed that the most useful way for Members to discuss the detail of this target and the NHS Board's performance to date was that a full paper be brought to a future meeting of the Committee. The paper would cover the steps being taken to achieve the HEAT target and the ongoing discussions around the setting of the original HEAT target and possible introduction of a new HEAT target.

DECIDED

- That the Integrated Quality & Performance Report be noted and that a paper be prepared for the Committee on reducing energy consumption and carbon emissions.

**Interim Lead
Director,
Acute Services**

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

There was submitted a paper [Paper No: 14/75] by the by the Medical Director on the handling of adverse clinical incidents together with an update on the current fatal accident enquiries.

In the absence of the Medical Director, Mr Andy Crawford, Head of Clinical Governance presented the report to the Committee and highlighted in particular the charts showing the time sequence of significant clinical incidents reported within the Acute Services Division and the Partnerships per month since April 2008.

In addition, the Avoiding Serious Events Monitoring Summary Report within Acute Services had proven useful in augmenting the existing review arrangements for patients' safety by adding an approach that created a more visible focus on indicators and assurance of improvement. Mr Crawford highlighted the implementation of the new revised Significant Clinical Incident Policy and that staff were now completing the review of their own local procedures to align them to the new policy requirements. The policy required evidence of a formal review for every severity event classified as 4 or 5. The paper set out the progress within each Directorate in Acute Services and some variations in practice had been noted and steps were being taken to ensure a more consistent approach was being followed within the Directorates when escalating incidents to be considered under the Significant Clinical Incident Policy.

In relation to questions from Members Mr Crawford agreed to review the presentation of Figure 1a in relation to the timeline shown and also a number of medication errors recorded in January and February 2014. He was hopeful that the new reporting and templates which had been established, including the summary page, ensured that the process and outcome was more visible and highlighted the outcome for patients and their relatives in a clearer way. In relation to the grade of the doctors involved in the incidents, Mr Crawford assured Members that where doctors were in a training role their local supervisor was notified to ensure a proper review was undertaken within a learning environment.

**Head of Clinical
Governance**

Ms Brown raised the increase in the number of Significant Clinical Incident investigations within the Women and Children's Directorate. She felt that the actions being taken with this Directorate required greater clarity of what was being addressed and how it was being addressed. Mr Crawford agreed to include this within the next report to the Committee.

**Head of Clinical
Governance**

Mr Fraser enquired as to whether the delay in a patient receiving Glucagon for an infusion was a common occurrence and Mr Crawford indicated that while this particular case was still being investigated, this had been a very unusual occurrence and any significant matters would be reported to the next Committee.

Ms Micklem indicated that with the improved safety culture it was clear that the number of cases had risen, however she wondered whether Mr Crawford would be able to give some indication as to when the numbers may settle again. He advised that he expected this to happen within Surgery and Anaesthetics shortly, however there was still a fair degree of variability with paediatrics and it may be a bit longer before a more settled pattern was established.

In relation to the update on the Fatal Accident Inquiries, Mr Calderwood advised that the Sheriff's Determination into the case relating to the 13 year old who had attended the Victoria Infirmary Accident and Emergency with her parent would be issued shortly.

NOTED

91. BOARD CLINICAL GOVERNANCE FORUM MINUTES (DRAFT) AND SUMMARY OF MEETING HELD ON 9 JUNE 2014

There was submitted a paper [Paper No: 14/76] enclosing the minutes of the Board Clinical Governance Forum meeting held on 9 June 2014.

Dr Benton asked about the Audit of Care Pathways for hip fracture patients in Scotland in relation to key interventions in the patient pathway from attendance at A&E to final discharge. There appeared to be significant variations. Mr Crawford agreed to review the information and share the outcome direct with Dr Benton.

**Head of Clinical
Governance**

NOTED

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

There was submitted a paper [Paper No: 14/80] 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.

This was the sixth report highlighting the work being undertaken within NHSGGC under the National Person-Centred Health and Care Collaborative and described the progress being made locally with the Pilot Improvement Teams in Clinical Services within the NHS Board's area. The report highlighted the fourth National Learning Session for the Person-Centred Health and Care Collaborative which had been held on 27 and 28 May 2014 at the Scottish Exhibition and Conference Centre, Glasgow. Over 100 staff from NHSGCC had attended and the NHS Board had won the "Story Board" prize. Plans were also underway for a third Person-Centred Health and Care Local Learning Session which was to be held on 26 August 2014.

The paper set out the feedback received from the "Themed Conversations" held with patients up until the end of April 2014. The data from the individual questions had been aggregated from all 21 Clinical Improvement Teams into nine themed sub sections and these included – Admission Experience; Respect and Dignity;

Communication and Involvement; Safety; Meal Time Experience and Environment and Facilities. There had been some concern with what was being fed back in relation to Meal Time Experience with patients regularly reporting not being offered suitable food and drinks at times acceptable to them. A revised questionnaire had been implemented from January 2014 and recent returns had shown an average 80% of patients being satisfied.

Members welcomed the report, its key messages and helpful case studies. Ms Micklem advised that she had spent a very helpful and useful day with the Clinical Governance Team. She had observed a Themed Patient Conversation and was impressed with the listening skills, patience and ability to obtain from the patient the critical information that allowed Managers to bring about improvements to services for patients. She also highlighted the Staff Feedback on pages 25 and 26 of the report and the acknowledgment that staff had been reassured that the findings from the patients would actually be used to drive improvements.

NOTED

93. UNSCHEDULED CARE

There was submitted a paper [Paper No: 14/77] by the Interim Lead Director, Acute Services, setting out the actions within NHSGGC following the Scottish Government's Announcement in 2013 of the 3 Year National Unscheduled Care Programme which was designed to ensure that patients were admitted or discharged from emergency departments as soon as possible with a view to ensuring that 95% of patients were treated in accordance with the standard by September 2014 and 98% by April 2015.

The NHS Board had prepared a local Unscheduled Care Action Plan and received additional funding from the Scottish Government of £1.6m and also £300,000 for the appointment of three additional emergency medical consultants. This allowed emergency department consultant staffing to be extended to midnight in all Acute sites except the Inverclyde Royal Hospital. A further plan was required to be submitted by 30 June to the Government for 2014/15 and it was to reflect that the National Funding for the emergency consultants would drop 30% this year. The draft plan had been prepared in conjunction with Acute Services and the Partnerships and approved by the Board's Strategic Unscheduled Care Group and also the Board's Medical and Nursing Directors, as was required by the Scottish Government.

Mr Archibald then highlighted the current performance which had been at 90% in recent months with only the Royal Hospital for Sick Children, the Vale of Leven Hospital and the Minor Injuries Unit meeting the 95% target. It was also acknowledged that in early June 2014 a significant number of patients waited over 12 hours in emergency departments. This in particular reflected a level of activity of 40% above the average emergency department attendances expected at the Victoria Infirmary. In addition, the total admission requirement was 33% above the average daily admissions to the Victoria Infirmary. Mr Archibald also highlighted the difficulties which had been experienced at the Western Infirmary, which continued to be the poorest performing emergency department within the NHS Board's area.

The paper set out a range of actions which were being taken across all areas of the Board as well as those actions being taken with key partners such as the Scottish Ambulance Services and Local Authorities. They were focused on developing ways

of supporting patients in their own home, supporting early discharge and improving the flow of patients in Acute hospital settings. One of the actions being considered was to move the Urology Services from the Western Infirmary to Glasgow Royal Infirmary 6-9 months ahead of schedule in order to create some additional space at the Western Infirmary which would allow an additional medical ward to be created. Also, an additional ward would be opened at the Southern General Hospital to create capacity for the south of the city and a dedicated Surgical Assessment Area and Discharge Lounge to be created at the Royal Alexandra Hospital.

Councillors Lafferty and Cunning enquired about the exceptional peaks on 1 and 2 June 2014 in terms of activity levels. Mr Archibald advised that the reviews undertaken to date had identified no specific factor associated with this increased activity and that the Director of Public Health and her staff were assisting in carrying out a further level of detailed investigation into the increased activity. The results of this investigation would be reported in due course. Exceptional peaks did, on occasion, occur and these were usually associated with particularly inclement weather, however this had not been a factor on this occasion.

**Interim Lead
Director, Acute
Services**

Ms Brown asked about the impact of boarding out of patients during this time. It was acknowledged that a significant level of boarding out did take place in order to cope with the number of patients who required admission following clinical review. The make up of beds had been re-balanced on occasion at the Victoria Infirmary and whilst very little elective surgery now took place there, it remained a hospital with a high A&E attendance. Difficulties such as boarding out were likely to continue until the Victoria Infirmary and Western Infirmary closed and the services moved to the New Southside Hospital in the May/June of 2015. In addition, it was reported that the Ambulatory Care Hospitals were now performing Day Case Surgery with rates which were above the Scottish average.

In discussing the proposed actions in order to meet the Scottish Government Health Directorate's requirement of 95% of patients being treated in accordance with the required standard by September 2014, Mr Archibald, in responding to Mr Lee's question, indicated that the additional non recurring and recurring finance set out in Appendix 1 was currently being discussed with the Scottish Government Health Directorate. These figures had not currently been taken account of within the NHS Board's approved Financial Plan. Dr Benton highlighted that delays in discharge from hospital could relate to factors wider than just difficulties accessing an ambulance to take a patient home. Mr Archibald acknowledged this and indicated that this was one of the areas where steps were being taken to try and ensure that a more consistent set of arrangements for discharges was in place. Ms Renfrew acknowledged the need for a whole series of improvements and this also related to better clinical processes and not just more beds. It remained a significant challenge to ensure better supported and organised services were available for patients within the community.

Mr Finnie found it difficult to clearly identify which parts of the service were working well and which were not. He highlighted the phrase within the current Action Plan which indicated that much of the expenditure on unscheduled care was embedded in the base budgets across Partnerships and the Acute Division and this expenditure had not been included with the Financial Planning table shown within the Action Plan. Mr Calderwood indicated that the costs to support unscheduled care formed part of the infrastructure. Ms Renfrew advised that there would in time be a need to reshape those embedded costs/services. The approved Acute Services strategy had envisaged a marginally smaller number of Acute Services beds which were better supported with less admissions and earlier discharges. The Change Funds were to assist in developing better supported home care and reductions in

delayed discharges where a patient had been clinically assessed for discharge however there continued to be delays in patients moving on to a more appropriate setting for their clinical needs.

There had been increases in the number of patients attending A&E Departments in recent years; however, those patients who were assessed as requiring to be admitted had increased significantly. The Board would receive papers in the near future describing possible redesign of the Community Services across Primary Care and the steps that they may be taking to ensure a more consistent achievement of the target set by the Government. This would include steps to meet the 95% target by September.

**Interim Lead
Director, Acute
Services**

DECIDED

1. That the Local Unscheduled Care Action Plan be approved for submission to Scottish Government.
2. That the requirements for additional recurring and non-recurring resources to support the provision of unscheduled care in 2014/15 be noted
3. That the intention to bring back an updated plan in association with the Winter Plan (2014/15) in November 2014 be noted.

**Interim Lead
Director, Acute
Services**

**Interim Lead
Director, Acute
Services**

94. DELAYED DISCHARGES

Members received a presentation from Ms Catriona Renfrew, Director of Corporate Planning & Policy and Mr Alex MacKenzie, Interim Director, Glasgow City CHP in relation to delayed discharges. Ms Renfrew highlighted the four targets which were required to be met and that the introduction of the £17m from the Change Fund had been provided with the primary purpose to assist in meeting these targets. Mr MacKenzie then provided the detail across NHSGGC in relation to delayed discharges and the actions and steps being taken in conjunction with the relevant Local Authorities to try and bring about improvements in meeting these targets.

In relation to a range of questions from Members, Ms Renfrew and Mr MacKenzie provided the following comments: The reason why Renfrewshire Council had such a good performance in this area was that the Council responded to demand for Care Homes and had not reduced their Care Home funding budget. In addition, they had allocated a social worker to patients still in hospital; this had also been replicated by East Renfrewshire Council.

Budget pressures were real and this had led, particularly within Glasgow, to a reduction in money allocated to Care Home funding. It was acknowledged that some early discharge of patients could lead to early readmission and this was a real issue which was being picked up and assessed as part of the review of this area. The relationship between the Board, Council and Cordia was acknowledged and any issues would have an impact on the new arrangements as they were part of the step-down model.

It was agreed to return to this issue for an update on the actions taken at the September NHS Board Seminar.

**Director of
Corporate
Planning &
Policy**

NOTED

95. CANCER WAITING TIMES

There was submitted a paper [Paper No: 14/78] by the Interim Lead Director, Acute Services providing Members a report on which steps had been taken to improve Cancer Wait Times.

The NHS Board had failed to meet the 62 day and 31 day targets for Cancer Waiting Times in the first quarter of 2014/15. As a result, a detailed action plan had been put in place which had been shared with the SGHD Cancer Performance Support Team. Following submission a support visit took place on 24 April 2014 and the Cancer Performance Support Team reported that they were reassured that the NHS Board were well informed on the detail and underlying causes for the recent below standard performance and were taking ownership and providing leadership and seeking solutions. Early indications were that performance had improved in relation to 31 day target such that the 95% target would be achieved (subject to data validation) in May 2014. There had been a small increase in the compliance rate in relation to the 62 day target. The paper set out the improvement measures being undertaken together with the specific measures in place for those patient pathways where the performance rate was below 90%; these being upper GI, urology, head & neck, breast and colorectal (screened) pathways.

Members welcomed this paper and the assurance it contained. Mr Winter asked in relation to the age profile of the medical staff whether an increased number of retirements would affect the service. Mr Archibald acknowledged that this had been identified as an issue and was being actively managed to ensure recruitment processes were smooth and commenced at the earliest possible time to reduce the possibility of any significant gaps between staff retiring and new staff starting.

NOTED

96. OPHTHALMOLOGY OUTPATIENT SERVICE

There was submitted a paper [Paper No: 14/79] by the Interim Lead Director, Acute Services asking Members to note measures which were being taken to address the Ophthalmology Outpatient Services pressures, specifically around the glaucoma service.

Ophthalmology referrals had increased at the rate of over 7% per annum and the most significant pressure was on the sub-specialty – glaucoma, due to increasing prevalence of this long-term, largely age-related condition. Once diagnosed, patients required a life time of follow up and this had led to increasing pressures on hospital capacity. It was acknowledged therefore that the Ophthalmology Service had found it increasingly difficult to maintain both the Waiting Time Guarantee and appropriate treatment intervals within available capacity. At the end of May 2014, 32 new glaucoma referrals had been waiting for more than 12 weeks for an outpatient appointment. In addition, the Glaucoma Service had no available return appointment slots in scheduled clinics within the next three months.

Mr Archibald highlighted the actions underway to bring about an improvement in the service. This included the Glaucoma Service being at the forefront of developing extended roles for hospital Optometrists and Orthoptists; the booking of clinic slots was subject to intensive oversight; increased optometry input from August 2014 would provide additional new patient slots; additional clinics were being arranged subject to the availability of staff; attempts would be made to secure locum support for the service and lastly, the Directorate was developing a revised

capacity plan to address the pressure on a recurring basis. There was recognition that with the summer holiday period, a reduction in clinic capacity would likely lead to a short term deterioration in waiting time positions within glaucoma however there was also an improvement in the medical staffing position, such that from August 2014 this would see the return of two consultants from maternity leave together with a full complement of junior doctors. It was recognised that it would be a number of months before this service returned to the National Waiting Time targets.

Mr Fraser asked if the development of the SIGN Guideline for shared care between hospital and community services would assist as this would possibly bring a better balance between hospital and community services. Mr Archibald acknowledged this would indeed be the case and Ms Brown saw benefits in an early redesign of the service to ensure greater community based services could be developed and supported.

NOTED

97. PRISON HEALTHCARE - UPDATE

There was submitted a paper [Paper No: 14/81] from the Interim Director, Glasgow City CHP providing Members with an update into the Prison Health Care Service which became the responsibility of the NHS in November 2011.

Health Care delivery at HMP Barlinnie and HMP Greenock became the responsibility of the NHS Board as did the services at the new build prison at HMP Low Moss when it opened in March 2012. There were health centres operating in each prison, delivering a range of Primary Care orientated health services for a total prison population of over 2,000 prisoners. The broad range of services delivered within each prison included GP, Dental, Addictions, Mental Health, Chronic Disease Management, Sexual Health, Podiatry, Pharmacy and Optometry. Each prisoner had their immediate health care needs assessed at the point of admission into prison and this included assessment of their risk to themselves and others. Those prisoners who served sentences of over six months were registered with the prison based GP service.

The paper highlighted that NHSGGC had been able to secure some salaried GPs, however there were still some vacancies and a large proportion of the shifts were covered by Bank locums. A recruitment drive for additional GP capacity was in progress with vacancies currently advertised. An Information Evening was planned for GPs to discuss Prison Health Care and encourage GPs to consider working within this environment.

Ms Jayne Miller, Service Manager for Prison Health Care also advised that the introduction of a complaints form had led to a significant increase in the number of complaints issued by prisoners, with the vast majority related to prescribing matters.

It was her intention to work with the Head of Corporate Performance and Reporting to develop a more comprehensive reporting regime on the work undertaken within the Prison Health Care Service.

Ms Micklem asked whether the services provided for prisoners were equivalent to those provided to the rest of the population. Ms Miller indicated that the service was very close to that standard and in some areas it had improved access for

prisoners to GPs and GDPs. Mr Finnie asked about the relationships with the HM Inspectors and comments within their reports which would have a bearing on the Health Care Services. Ms Miller advised that there were very close working relationships with the Inspectors and their comments and suggestions had led to useful improvements to the services provided.

Ms Brown asked about the knock on effect from the issue affecting Grampian. Ms Miller advised that prisoners had indeed been transferred to Glasgow as service movement was undertaken within Grampian and that unfortunately had continued. Discussions were ongoing on the resulting cost pressures which had resulted from these temporary arrangements.

Dr Benton enquired about learning disability screening on admission and the outcome of that screening. Ms Miller advised that this was used to pick up the most serious learning disability concerns and of the 2,500 prisoners screened, nine had been identified for treatment and a pathway had been developed with access to other services. In relation to possible suicides, once an assessment had been made referrals would be made onwards to the GP services.

Members welcomed this helpful and comprehensive report and thanked Ms Miller.

NOTED

98. FINANCIAL MONITORING REPORT FOR THE 2 MONTH PERIOD TO 30 MAY 2014

There was a verbal update by the Director of Finance.

Mr James reported that, as at Month 2, the NHS Board was in £1m overspend. This was broken down to £800,000 overspend within the Acute Services Division and £200,000 overspend within Partnerships. This was to be expected at this time in the financial year and full written reports would be considered by the NHS Board from Month 3 going forward.

NOTED

99. MEDIA COVERAGE OF NHSGGC MAY-JUNE 2014

There was submitted a paper [Paper No: 14/82] by the Director of Corporate Communications highlighting outcomes of media activity for the period May - June 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.

Mr McLaws highlighted the new Master Chef Style Competition launched by the Scottish Government to recognise the best hospital catering in NHS Scotland. This announcement was linked to previous criticisms of NHSGGC catering and the overall tone of coverage for the NHS Board was therefore negative. Secondly, the publication of the new guidance on junior doctors' hours by the Scottish Government was widely reported and linked to the unfortunate death of a junior doctor who had formerly worked at Inverclyde Royal Hospital and again the overall tone of the reporting for NHSGGC had been negative.

NOTED

100. 2013-14 ANNUAL REVIEW TIMETABLE

There was submitted a paper [Paper No: 14/83] by the Director of Corporate Planning and Policy setting out the timetable for the 2013/14 Non Ministerial Annual Review which was scheduled to take place on the afternoon of Tuesday 19 August 2014.

The NHS Board Meeting would be held at 9:30 am on the morning of 19 August and the Annual Review would follow in the afternoon with the public session being held at the Marriott Hotel.

NOTED

101. QUALITY POLICY DEVELOPMENT GROUP MINUTES OF MEETING HELD ON 29 APRIL 2014

There was submitted a paper [Paper No: 14/84] enclosing the minutes of the Quality Policy Development Group meeting of 29 April 2014.

NOTED

102. STAFF GOVERNANCE COMMITTEE MINUTES OF MEETING HELD ON 20 MAY 2014

The minutes of the Staff Governance Committee held on 20 May 2014 [SGC (M)14/02] were submitted to the Committee.

NOTED

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

There was submitted a paper [Paper No: 14/85] 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 16 June 2014, 169 weeks of the 201 week contract had been completed and the project remained within timescale and budget. The contract completion date remained as 26 January 2015 and this would include the handover of the Adult and Children’s Hospitals and Car Park 1. Good progress continued to be made in terms of both the Adult and Children’s Hospitals and the Quality Control Inspection process being undertaken by Capitta Simmons was ongoing and to date they had jointly inspected 88 areas with the contractors; overall this accounted for over 3,100 rooms. The NHS Project Teams’ zone checking was ongoing as areas became available for final inspection; the latest areas were the Outpatient and Renal areas within the Adult Hospital and the Acute Receiving Unit within the Children’s Hospital.

The paper updated Members on the progress with imaging equipment and the transfer of equipment together with the progress in construction with the Teaching

and Learning Centre (due for completion by the end of May 2015) and the new staff office accommodation (due for completion by April 2015).

Mr Ross took Members through the change control process in relation to compensation events and whilst no compensation events had occurred since the last report, the potential compensation events in relation to adverse weather, the works associated with the Institute of Neurological Sciences and some changes associated with the possible operation of the fast link/bus stops would not lead to any additional costs for the NHS Board.

Ms Brown enquired about the issue she had raised at the Board's Away Day earlier in the year in relation to the location of the Children's Mental Health Ward. Mr Calderwood indicated that this issue would be picked up in a future paper to the Committee in terms of its location and any alternative options.

**Project Director
– NSGH Project**

Good progress continued to be made as the contract entered its final 30 weeks and the Committee would continue to receive regular reports in order to monitor the progress as the contract neared completion.

The paper highlighted that the Committee had approved the NHS Greater Glasgow and Clyde Food Retail Policy at its last meeting and this policy had subsequently been approved by the NHS Board at its June meeting. The retail strategy for the New South Glasgow Hospital's development would incorporate the policy guidelines and recommendations, and steps were now being taken to set out recommendations for engaging with non food vendors for the new hospital.

There would be circa 10,000 NHS staff expected to be on the site with circa 300,000 patient attendances per annum together with visitors and contractors. This drove the requirement for retail and other services to serve a range of needs and differing expectations in terms of product and price. The commissioned retail consultant advised that owing to the physical dimensions of the available floor areas, that mainstream food retailers may not be attracted to operate from the site. The intention therefore was that NHS Aroma operated the 450 seat restaurant/cafe on the first floor within the atrium (which was accessed via elevators from the main concourse) and it would also manage the beverage outlets on the ground floor. In addition it was proposed that cash machines be located in both hospitals and that two areas be actively marketed to attract a grocer/convenience store and a newsagent's retail outlet that would hopefully incorporate a post service and a trolley service. In addition the Board had received notification of interest from the third sector and staff representatives' organisations to occupy space within the Adult Hospital.

In relation to the Children's hospital it was suggested that Aroma manage the beverage outlet and Yorkhill Children's Charity had previously intimated their interest in occupying a space to use as a gift shop.

It was intended that a procurement process test market demand for a grocer and newsagent services and that an advertisement be placed in the commercial property pages to draw attention to this opportunity and interested retailers would be invited to apply via a tendering package. In relation to the third sector and staff side organisations, including Yorkhill Children's Charity, the NHS Board would notify them of the available opportunities within the new hospitals and seek expressions of interest where commercial terms were deemed appropriate.

Councillor Cunning was keen to ensure that any specification for such services included the need for affordable and value for money items in order to avoid an

unfair pricing strategy that may reflect a captive audience and a lack of competition within the site. Ms Micklem was keen to ensure that the selection criteria for the third sector was fair and it was acknowledged that those developing the selection criteria would need to be sensitive to the different organisations and charities who may wish to be represented and provide services from the new hospitals.

Mr Calderwood acknowledged that the measures proposed were not seeking income generating opportunities but the right balance and mix of services for patients and visitors and a report would be submitted back to the NHS Board Members with the outcome. He recognised that the service to be offered by Aroma was large scale but that this was the NHS Scotland brand and it had turned around a year on year deficit into an annual budget surplus. Mr James was concerned at the move to forego revenue opportunities on the new hospital development, however Members recognised the community based approach and the intention to get the best suppliers possible for patients, visitors and staff. The Committee therefore were content to proceed with the recommendations contained within the paper.

In relation to the proposed over cladding works to the Neurosurgical building within the Institute of Neurosciences a Capital Planning Business Case was submitted for consideration.

The site master plan had identified a range of works that required to be undertaken to the Institute of Neuroscience to enhance delivery of NHS clinical services, enable investment by the University of Glasgow to the Clinical Research Facility Phase 2 and extend the operation of the building. One area of works identified for the Institute was a potential over cladding works to enhance the appearance of the building and prolong the life of the building. The estimated Capital cost for the project was £3.2m excluding VAT. Expenditure for the project was approved as part of the NHS Board's 2014/15 Capital Plan. The paper indicated that there were various options to procure the works and the recommendation was that in order to avoid potential for split warranties and future risks of disputes, the NHS Board should consider a negotiated procurement route with Brookfield Multiplex, the works being a compensation event to the main hospital works. To go down this route the paper identified those steps which would create the correct framework and commercial tension to develop a value for money target price.

Mr Loudon advised that this would lead to the replacement of windows and general improvements. Members were supportive of the recommendation.

DECIDED

1. That the progress report on the development and construction of the New Adult and Children's Hospitals at the South Side be noted.
2. That the NHS Board proceed with the recommended procurement processes for a grocer and newsagent services as noted in the paper.
3. That the Board proceed to enter into a dialogue with third sector, staff organisations and Yorkhill Children's Charity regarding their proposals to occupy outlets.
4. That the Retail Consultant be retained to prepare the proposed advert, tender documentation and lease documentation (with support from the Central Legal Office) were required.
5. That the Board implement a negotiated procurement route with Brookfield

**Project Director
– NSGH Project**

**Project Director
– NSGH Project**

**Project Director
– NSGH Project**

Multiplex, with the key steps noted in terms of demonstrating value for money, in relation to giving approval to the Capital cost of £3.2m excluding VAT for the provision of the over cladding works to the Neurosurgical Building, New South Side Hospital.

104. FULL BUSINESS CASE FOR THE WEST OF SCOTLAND SATELLITE RADIOTHERAPY FACILITY

There was submitted a paper [Paper No: 14/86] by the Interim Lead Director, Acute Services providing an update in relation to the West of Scotland Satellite Radiotherapy Facility at Monklands Hospital, Airdrie. The Full Business Case was formally approved by the SGHD Capital Investment Group on 22 April 2014 and construction on site started on 27 May 2014 with the Breaking Ground Ceremony taking place on 16 June by the Cabinet Secretary for Health and Wellbeing. It was anticipated that the construction completion date would be the end of August 2015 with clinical services commencing by the end of November 2015. The agreed cost of construction was £21,948,035 (excluding VAT) and this included over £4.6m for equipment, mainly the two Linear Accelerators for radiotherapy service provision. NHS Lanarkshire was responsible for the governance and approvals in relation to this West of Scotland Development and the West of Scotland Project Management Group had now become the Lanarkshire Beatson's Development Project Board and it would meet two monthly in order to oversee the project up to the scheduled completion date in November 2015.

Mr Winter asked about the approval process for the Final Business Case. Mr Calderwood intimated that NHS Lanarkshire took this responsibility forward for all West of Scotland Health Boards associated with this scheme. NHSGGC would recruit the clinical staff, would be responsible for the IRMER regulations and would hold the medical records as part of the Beatson Oncology Centre Service located at Gartnavel General Hospital. In relation to the provision of equipment Mr Calderwood advised that the Linear Accelerators were purchased on a national basis by NHS National Services Scotland. The new arrangements would lead to an additional Linear Accelerator together with a replacement for one of the twelve machines located within NHSGGC. Mr Lee was concerned that the physical asset of the equipment would be on the books of NHSGGC and there was an ongoing revenue commitment. In addition Mr Winter was concerned that the Capital Expenditure of the project had not been approved by NHSGGC and therefore what would the implications be for the contract being overspent. Mr Calderwood advised that the contract would be monitored by NHS Lanarkshire and if the contract did overrun or exceed budget these were discussions which NHS Lanarkshire would have with SGHD.

Mr Lee indicated that the approved Business Case made it clear that NHSGGC would receive the funding and therefore be responsible and accountable for the equipment and asked that this be looked at in relation to the NHS Board's responsibilities also the adequacy of the Standing Financial Instructions. It was agreed that both issues would be reviewed to see if any changes were required.

**Director of
Finance**

NOTED

105. GLASGOW DENTAL HOSPITAL AND SCHOOL – PHASED MODERNISATION AND INFRASTRUCTURE PROGRAMME – LEVEL 3 PROPOSALS

There was submitted a paper [Paper No: 14/87] by the Director of East Dunbartonshire CHP seeking approval to an allocation of Capital Funds from the NHS Board's approved Capital Plan for a phased modernisation and infrastructure upgrade programme – level 3 proposals for Glasgow Dental Hospital and School.

Glasgow Dental Hospital was the Hub for specialist and secondary care dentistry within the NHS Board's area and for specialist dental treatment for patients from other West of Scotland Health Boards. There had been previous significant investment in the refurbishment of the Dental Hospital with £12.4m spent since 2008/9. However further work was required to maintain the building in a fit for purpose state and the NHS Board's current Capital Plan recognised the need to continue to invest with £2.5m being allocated across 2014/15 and 2015/16. The next step in this ongoing refurbishment work was the development of level 3 as set out within the paper.

DECIDED

1. That the allocation of £1.5m as part of the Board's 2014/15 Capital Plan and proposed allocation of £1m for 2015/16 be approved.
2. That the Oral Health Directorate's proposal for the redevelopment of level 3 of Glasgow Dental Hospital subject to tenders being received within the allocation available, be approved.
3. That the scheme over the current and next financial year was the priority option for the ongoing modernisation programme for the Glasgow Dental Hospital and that further modernisation and plan for infrastructure investment be recognised as required to levels 4, 5 and 6 as capital became available in future years.

**Director, East
Dunbartonshire
CHP**

**Director, East
Dunbartonshire
CHP**

**Director, East
Dunbartonshire
CHP**

106. RECOMMENDATIONS REPORT FOR THE SECONDMENT OF SCOTTISH FUTURES TRUST RESOURCES TO SUPPORT THE PLANNED ASSETS DISPOSAL PLAN

There was submitted a paper [Paper No: 14/88] by the Chief Executive and the Project Director, New South Glasgow Hospitals Development indicating that Officers had identified a range of assets which were considered to be surplus to future requirements and therefore as a consequence would move to dispose the assets with the objective to generate capital receipts.

Following discussions with the Scottish Government and the Scottish Futures Trust (SFT) the Board had acknowledged that it did not possess the requisite professional skills in-house to professionally manage the complex transitions required to deliver the disposals programme. SFT was currently providing support to the Board and it was recognised that additional resources would be required to meet or improve upon the current programme. SFT had confirmed that the cost of the additional resources would be met by the Scottish Government Enabling Fund and therefore there would be no cost liability to the NHS Board. The paper set out the disposal programmes for a range of sites across the NHS Board's area.

There was an obligation on the NHS Board to ensure the required governance was in place to provide decision making processes for the disposal programme team and this was likely to follow a regular Disposals Programme Meeting with the Capital Planning and Property Department; the Monthly Capital Planning and Property Board and the bi-monthly Quality & Performance Committee.

Lastly, additional support, governance and fact finding would be required from existing in-house NHSGGC Capital Planning and Asset Management Staff.

DECIDED

- That the NHS Board's engagement with Scottish Futures Trust, and the proposal to access additional resources recruited and funded by SFT to support the proposed disposals plan, be approved.

**Project Director
– NSGH Project**

107. DATE OF NEXT MEETING

9.00am on Tuesday 16 September 2014 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 12.50pm