DRAFT

QPC(M)14/06
Minutes: 139 - 164

NHS GREATER GLASGOW AND CLYDE

Minutes of the Meeting of the Quality and Performance Committee at 9.00 am on Tuesday, 18 November 2014 in the Board Room, J B Russell House Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH

P R E S E N T

Mr I Lee (Convener)

Dr C Benton MBE	Cllr A Lafferty
Cllr M Cunning (To Minute 156)	Ms R Micklem
Mr P Daniels OBE	Cllr J McIlwee
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

Dr J Armstrong (To Minute 144)	Mr R Finnie
Mr R Calderwood	Mr A O Robertson OBE
Cllr M Devlin	Rev Dr N Shanks

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

Mr G Archibald	..	Chief Officer, Acute Services
Ms A Baxendale	..	Head of Health Improvement (For Minute 153)
Ms J Carson	..	Adult Services Manager (For Minute 154)
Mr A Curran	..	Head of Capital Planning and Procurement (For Minute 157)
Mr M Feinmann	..	Director, North East Sector (Glasgow City CHP) (To Minute 157)
Mr K Fleming	..	Head of Health and Safety (To Minute 150b)
Mr A Gallacher	..	Technical Manager (To Minute 150c)
Mr R Garscadden	..	Interim Director of Corporate Affairs (To Minute 148)
Mr J C Hamilton	..	Head of Board Administration
Mr J Hobson	..	Interim Director of Finance
Mr D Loudon	..	Project Director - South Glasgow Hospitals Development (From Minute 150)
Mr N McGrogan	..	Head of Community Engagement (For Minute 156)
Mr A MacKenzie	..	Interim Director, Glasgow City CHP (For Minute 145)
Ms M Macleod	..	Project Manager (For Minute 156)
Mr S McLeod	..	Head of Specialist Children's Services (For Minute 157)
Ms T Mullen	..	Acting Head of Performance and Corporate Reporting
Ms C Renfrew	..	Director of Corporate Planning and Policy (To Minute 147)
Mr D Ross	..	Director, Currie & Brown UK Limited (For Minute 156)
Mr D Walker	..	Director, South Sector (Glasgow City CHP)
Mr R Wright	..	Director of Health Information Management (To Minute 153)

ACTION BY

139. APOLOGIES AND INTRODUCTION

Apologies for absence were intimated on behalf of Ms M Brown, Dr H Cameron and Dr D Lyons.

The Convener asked the Committee for its agreement to re-order the agenda and permit particular Directors to present their papers earlier than planned to allow them to attend their respective meetings. This was agreed.

Mr Fraser asked that consideration again be given at the NHS Board's Away Sessions to the remit and responsibilities of the Quality and Performance Committee as yet again it was an agenda with over 25 items and 435 pages. This was agreed. **Chief Executive**

The Convener, on behalf of the Committee, congratulated Mr Grant Archibald on his recent appointment as Chief Officer, Acute Services Division.

140. DECLARATIONS OF INTEREST

Councillor McIlwee declared an interest in the following two agenda items:-

(i) Public Bodies Joint Working Act: Update on Implementation

(ii) HUB Programme Update

141. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No: 14/118] by the Acting Head of Performance and Corporate Reporting setting out the integrated overview of NHSGGC's performance.

Of the 44 measures which had been assigned a performance status based on their variance from trajectory and/or target, 22 were assessed as green; 8 as amber (performance within 5% of trajectory) and 14 as red (performance 5% outwith meeting trajectory). The performance in relation to Child and Adolescents accessing Mental Health Services, while shown as red, was in relation to NHSGGC's own target and with 99.4% of these patients referred to treatment in under 18 weeks, this was amber when measured against the national target.

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

- Antenatal care (SIMD) had moved from amber to green;
- Percentage of new outpatient appointment DNAs had moved from red to amber;
- MRSA/MSSA bacteria cases per 100,000 AOBDs had moved from green to red;
- Cancer treatment waits 31 days had moved from green to amber;
- Alcohol brief interventions had moved from green to red;
- Freedom of Information requests had moved from green to red.

Exception reports had been provided to members on the measures which had been assessed as red.

Ms Micklem thanked Officers for the use of the proforma following the approval and implementation of the supporting guidance. It was clear there was a great improvement in this area and she wondered whether officers bringing reports to the Quality and Performance Committee might follow this example. She went on to say that it seemed likely that as resources became tighter it was possible that performance in some areas may not be sustained and more HEAT targets/performance indicators may not be met. It would be better that the Committee focused on the key priorities of NHSGGC and ensure significant effort around meeting these targets while accepting that some targets may remain difficult to achieve.

There was agreement to this approach and this would form part of the discussions in bringing together the Financial Plan and Strategic Plan for 2015/16. **Director of Corporate Planning & Policy**

Mr Fraser welcomed the weekly update provided by the Communications Directorate on media issues. In relation to Freedom of Information requests received from the media, he wondered if enough was being done to try and deal with some of these as "business as usual" requests. It was reported that such efforts were made with sections of the media however, despite this there had been a nearly 60% increase in media-generated Freedom of Information requests in the last quarter, many from independent journalists. This level of increase had been sustained into the third quarter of the year.

Dr Armstrong agreed to pick up in her report on Healthcare Associated Infection on Mr Finnie's concern that the work going on to reduce MRSA was not reflected within the exceptions proforma of the Integrated Performance Report and more consistency was needed with what was reported in the Healthcare Associated Infection: Exception Report.

NOTED

142. SCOTTISH PATIENT SAFETY PROGRAMME REPORT

There was submitted a paper [Paper No: 14/119] by the Medical Director on the Scottish Patient Safety Programme and in particular, an update on the Hospital Standardised Mortality Ratio (HSMR) in relation to the position at the Royal Alexandra Hospital/Vale of Leven Hospital.

Plans had been put in place to review a number of factors in order to establish an improvement following Healthcare Improvement Scotland (HIS) contacting the NHS Board about the HSMR rate at the Royal Alexandra Hospital/Vale of Leven Hospital being more than two standard deviations from the mean for the quarter January-March 2014. Engagement had been held with clinical staff to seek a longer-term improvement and whilst the HSMR had reduced from 0.99 to 0.94, when compared with other Scottish hospitals, the level of improvement was not as great as that achieved in other Scottish hospitals. Dr Armstrong described the work being undertaken in seeking a longer-term improvement plan and additional analysis being undertaken to understand the factors which could explain why the HSMR rate was higher at the RAH/VOL in comparison with other hospitals. When finalised, the full report would be shared with local services and would be considered through the Strategic Review by the Acute Services Division Clinical **Medical Director**

Governance Forum.

Some discrepancies between a primary diagnosis for the patient's final admission to hospital and cause of death had been noted and this may suggest some coding problems or a further possible limitation in using HSMR as marker of quality of care in hospitals. The clinicians were currently reviewing all case notes. Following a visit and discussion with the Medical Director, it was clear that there was a strong cross-disciplinary interest in creating a longer-term improvement plan for the hospital; identifying and supporting clinical leadership for improvement; improving care for deteriorating patients; carrying out routine mortality reviews and integrating with other improvement and management actions were all underway.

Dr Armstrong would ensure that Members were kept up to date with the progress in this important area. **Medical Director**

NOTED

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

There was submitted a paper [Paper No: 14/120] by the Medical Director on the handling of adverse clinical incidents together with an update on the current Fatal Accident Inquiries. A new format of reporting had been devised to increase the transparency of safety-related incidents occurring within NHS Board services and the provision of data on significant clinical incidents (SCIs), a broader insight into other types of adverse events and the monitoring undertaken on the Significant Clinical Incident Policy.

In response to the Committee's request for additional information in order to fully understand the pattern of reporting levels within the Women and Children's Directorate, especially in relation to the doubling of the number of investigations over the past four years, Dr Armstrong drew attention to the first table in the report. This provided an overall distribution of SCIs in each of the three service domains (obstetrics and gynaecology, paediatrics and neonatal). It highlighted that an increase in overall levels was being driven by greater reporting in both paediatrics and obstetrics and gynaecology. The reporting levels were known to be associated with the prevailing safety climate and the threshold of concern for reporting by clinical staff. In relation to the coding, codes 3 and 4 (minor system of care issues and major system of care issues) indicated where an investigation suggested deficiencies in the care provided. The data presented indicated that one third of SCIs related to investigations within codes 3 or 4. The Division ran at two thirds of SCIs relating to codes 3 and 4. This, again, confirmed the higher level of reporting was due to the improved safety climate and greater use of the new SCI Policy. The Princess Royal Maternity Hospital had a higher level of SCI investigations however, those assessed as codes 3 and 4 remained comparable with the other maternity units.

The Women and Children's Directorate and Acute Services Division repeatedly reviewed SCIs and specific improvement plans were created for each event and shared across services in order to maximise learning. Members welcomed this additional level of reporting and the assurances contained within the paper. Members felt encouraged that staff were being supported to raise any relevant concerns under the SCI Policy. Members also welcomed the summary provided of the key issues and the ability to delve into specific areas of detail where necessary.

The Convener indicated that in addition to submitting his apologies, Dr Lyons had set out some key questions he would like the Committee to consider. In response to a request for an update on a recent suicide, Dr Armstrong indicated that she was meeting Dr Lyons soon and would cover this matter with him then. **Medical Director**

NOTED

144. HEALTHCARE ASSOCIATED INFECTION: EXCEPTION REPORT

There was submitted a paper [Paper No: 14/121] by the Medical Director providing information on the performance against the national targets for key infection control measures.

For Staphylococcus aureus Bacteraemia (SABs), the most recent validated results for April – June 2014 demonstrated an SAB rate of 26.4 per 100,000 acute occupied bed days (AOBDs), which was below the national average of 33.4 cases. Dr Armstrong reminded Members of the increase across Scotland including NHSGGC, and following the implementation of the new policy in relation to PVCs, initially piloted at the Royal Alexandra Hospital, and then the current moves to implement it across the Board's 400 wards, it was clear that the impact had been significant, with a circa 18% reduction in one quarter. The data was still to be validated and the implementation was ongoing but it had been an encouraging turnaround and other NHS Boards had contacted NHSGGC about how the improvements were being achieved. Mr Finnie welcomed this response in relation to his questions about the rate of infection, and asked if, in future, such information could be tied back to the Integrated Quality and Performance Report to ensure consistency between both papers. This was agreed. **Medical Director**

With regard to the C-Difficile rate for April to June 2014, the NHS Board had a rate of 26.4 cases per 100,000 AOBDs which, again, was below the national average of 33.4 cases.

NOTED

145. WINTER PLANNING – 2014/15

There was submitted a paper [Paper No: 14/123] by the Chief Officer, Acute Services Division, setting out the additional arrangements which had been put in place for this winter and which updated the NHS Board on the issues around delayed discharges.

Mr Archibald took Members through each element of the additional arrangements put in place in planning for winter 2014/15. He advised that he was meeting with the Chief Executive later that day to ensure a robust set of plans were in place and he reminded Members that the NHS Board's Unscheduled Care Plan had been submitted to the Scottish Government at the end of September 2014.

In relation to the continuing concerns about the level of delayed discharges, Mr MacKenzie advised that the most up-to-date figures showed, for the first time, a reduction (from 201 to 193) of patients awaiting discharge within the Glasgow City Council area. He also advised that the paper on which Members had received a copy from Mr D Walker, Director of South West Glasgow CHP had now been approved by the Council and funding secured for the proposals relating to step

down arrangements from the end of September, the commissioning of additional nursing home places (28 from December 2014) and other key areas targeted at reducing the number of delayed discharges within Glasgow. The Scottish Government had allocated an additional £1.183m of non-recurring funds to assist with these plans and it was hoped to see a reduction of around 50 cases within the next few weeks.

Mr Fraser enquired as to the progress with the staff immunisation for influenza and it was agreed that the latest figures would be sent to Members as soon as possible. **Director of Public Health**

NOTED

146. INEQUALITIES – FAIR FINANCIAL DECISIONS

There was submitted a paper [Paper No: 14/126] by the Director of Corporate Planning and Policy advising that it was a requirement of the Equality Act 2010 that the NHS Board assess any risks in relation to the equality impact of cost savings and the report provided details of the process for 2014/15 and identification of where full Equality Impact Assessments were required.

The rapid impact assessment approach now formed an integral part of the process in the Acute Services Division and Partnerships on service redesign where cost savings were expected to be released. This approach had identified those service redesigns which would require a full Equality Impact Assessment to ensure that risks with regard to protected characteristics were fully considered and the table attached to the report identified those Equality Impact Assessments which required to be completed by March 2015.

Ms Micklem welcomed this process and believed it provided a clear rationale for financial decisions and guarded against opportunistic savings. She did however, wonder about the tone in terms of being very risk-based when the equalities legislation also sought positive opportunities for improvement. Ms Renfrew acknowledged this and said that steps would be taken to present this information to managers in that light. **Director of Corporate Planning & Policy**

NOTED

147. PUBLIC BODIES JOINT WORKING ACT: UPDATE ON IMPLEMENTATION

There was submitted a paper [Paper No: 14/127] by the Director of Corporate Planning and Policy which provided an update to the Committee on progress on working towards delivering the requirements of the Public Bodies Joint Working Act. Ms Renfrew took members through different sections of her paper as follows:-

(a) Regulations – The paper provided an extract from the information laid before Parliament and drew out the key elements which would be required to inform the development of Integration Schemes, organisational change and further development of Schemes of Delegation. The Act required each NHS Board and Local Authority to delegate functions to the Joint Integrated Partnership Boards and the intention was to create a single system for local joint strategic commissioning of health and social care services which was built around the needs of patients and service users.

The Act set out which adult health and social care functions were to be delegated and whilst the legislation did not include children's health and social care services, it would be a matter for local systems to decide whether to integrate children's services as well as adult services. One significant issue was the inclusion of planning for emergency care as a responsibility for each Integrated Joint Board. Establishing an approach to planning and costing which maintained service cohesion would be challenging.

(b) Integration Scheme – Integration Schemes were being developed in each Integrated Joint Board using the Model Scheme which was attached to the paper. The intention was that the final versions of the Integrated Schemes would be presented to Members for approval in January 2015. **Director of Corporate Planning and Policy**

(c) Strategic Planning – The NHS Board Seminar had discussed the approach to developing a strategic direction based on the final year of the 2013/16 Corporate Plan. Joint Integrated Partnership Boards were developing an approach to strategic planning based on Scottish Government Health Directorate guidance and the responsibilities of Integrated Joint Partnership Boards for planning emergency care would come into effect from 2016/17.

(d) Chairing and Membership – The last meeting of the Committee approved the proposal for discussion with the different Local Authorities covering arrangements for the first Chair of the Integrated Joint Boards and the number of voting members on each Board. The paper presented the responses from each Local Authority; it was clear that nearly all Local Authorities wished to have the first Chair of the Joint Integrated Board. Members debated this point and concluded that on the basis of the responses, an approach should be made to see whether a joint chairing arrangement was possible. Ms Renfrew would make contact with the Local Authorities to see if they would be amenable to this model before opening up discussions with the Scottish Government Health Directorate. **Director of Corporate Planning and Policy**

The need to pull together finalised Integrated Plans for consideration in January 2015 was recognised as key and these plans would incorporate local alignment where acceptable for children's services and also cover the agreed hosting arrangements, particularly for services where cross-system working was critical for successful delivery. Chief Officers would be required for these services to ensure a collective arrangement to oversee planning, resources and staffing.

There would be an opportunity at the NHS Board's Away Sessions on 8 and 9 December to further discuss the arrangements in setting up the Joint Integrated Partnership Boards as well as the intentions around strategic planning and the chairing arrangements for Joint Integrated Boards.

148. ACUTE HOSPITAL BROADCASTING

There was submitted a paper [Paper No: 14/132] by the Nurse Director setting out proposals on the future of radio broadcasting delivered by voluntary organisations to Acute Hospital sites within NHSGGC. The proposal was to discontinue hospital radio as delivered by voluntary organisations on those sites impacted by the moves to the new South Glasgow University Hospital. In addition, there was continued support for individual patient-based entertainment systems as the primary entertainment system for patients within these hospitals.

In the absence of Ms Rosslyn Crocket, Nurse Director, Mr Roy Garscadden presented the paper on her behalf. Radio broadcasting to Acute Hospitals was currently delivered by three charitable organisations run by volunteers: Southern Sound Hospital Broadcasting, located at the Southern General Hospital, Victoria Infirmary Radio located at the Victoria Infirmary and the Hospital Broadcasting Service located in private accommodation in Glasgow. Each was registered as a charity and delivered services to different sites across the area. Dialogue was entered into with the volunteers on the future of radio broadcasting to adult hospitals, particularly in light of the moves to the new South Glasgow University Hospital.

Victoria Infirmary Radio recently acknowledged that on the closure of the Victoria Infirmary in 2015, the services from that site would discontinue and they would merge with the Hospital Broadcasting Service. Southern Sound currently occupied accommodation which was to be demolished on the Southern General site and they would favour a relocation to a site in Govan with the request that the NHS Board pay the relocation costs.

Current radio broadcasting was based on traditional analogue methods with a dedicated radio point at the bedside however, the infrastructure was old and required regular maintenance and less than 50% of patients in hospitals were able to access the system. The new South Glasgow University Hospital would have an individual patient-based entertainment system at each bed with dedicated Freeview TV and radio channels with the signal presented through the network. In addition, patients were increasingly bringing their own personal means of listening to music into hospital and would also have access to digital TVs in the individual patient bedrooms which also accessed numerous radio channels. The Board's strategic direction was based on the individual patient-based entertainment system and this, through time, would be extended across all acute hospital sites. This would mean that the existing broadcasting systems to acute hospitals would be phased out and therefore it would be necessary to give notice to quit to Southern Sound prior to the opening of the new South Glasgow University Hospital, to take effect at the end of the financial year 2014/15.

Radio Lollipop, at the Royal Hospital for Sick Children, would continue due to the nature of the hospital, the length of inpatient stay and the interaction with patients, carers and children. In addition, the individual patient system at the Beatson Oncology Centre would continue.

Members accepted the position described in the paper but realised this was a sensitive area where many volunteers had given up their time over many years and they endorsed the plan to hold a reception to thank and recognise those who had made a contribution to the radio broadcasting service to hospitals within NHSGGC over these years.

The Convenor asked about patients accessing the wider internet within hospital, and Mr Wright advised that he would look into this across all hospital sites and report back to the Members on the availability of internet access. **Director of Health Information & Technology**

DECIDED

1) That, a notice to quit to Southern Sound from accommodation at the Southern General Hospital be approved. **Nurse Director**

2) That, a reception for Southern Sound and Victoria Infirmary Radio for **Nurse Director**

radio services delivered to patients in the South Glasgow area over many years, be approved.

3) That, dialogue continue with the Hospital Broadcasting Service to discuss the pace of implementation of the individual patient entertainment system to acute hospitals within NHSGGC. **Nurse Director**

149. MINUTES OF PREVIOUS MEETING

On the motion of Mr K Winter and seconded by Councillor J McIlwee, the Minutes of the Quality and Performance Committee Meeting held on 16 September 2014 [QPC(M)14/05] were approved as a correct record.

150. MATTERS ARISING

(a) Rolling Action List

NOTED

(b) Action Taken to Combat Violence Against NHS Staff

There was submitted a paper [Paper No 14/116] by the Head of Health and Safety informing Members of the range of control measures, systems and procedures which were currently in place across NHSGGC in order to reduce the risk of violence and aggression towards staff.

Mr Kenneth Fleming, Head of Health and Safety, presented his report and highlighted the following:-

- Over the last five years, the recorded violence and aggression data (that is, physical assaults, threats and verbal abuse) had fallen from 9,811 in 2009/10 to 8,526 in 2013/14.

- In 2013/14, 69 incidents were reported under statute to the Health & Safety Executive due to violence or aggression; this was an increase from the 50 cases reported last year.

- Stalking policy was reviewed and reissued in October 2013; a restraint policy had been developed and would be submitted to the Board Clinical Governance Forum for approval by the end of the calendar year, and the three-year violence reduction strategy implementation was overseen by the Violence Reduction Group, which also reviewed the total number of recorded incidents and trends.

- Four cases in each of the last two years have gone to court following a report to the Procurator Fiscal's Service; this was down from 14 in 2011/12 and 38 in 2010/11.

- Recording on Datix now provided details of incidents where patients' medical conditions had been recorded as a factor when related to violence and aggression. The most common medical condition was dementia followed by psychiatric disorder.

Mr Fleming described the training in place, support for staff and security arrangements and the promotion of awareness of violence and aggression, stress in the workplace and incident reporting. He acknowledged the possibility of likely under-reporting of verbal aggression incidents and also anecdotally, some actual physical violence incidents had not always been reported in a timeous manner.

Members welcomed this helpful report and Mr Sime advised that the Staff Governance Committee received an Annual Report from the Head of Health and Safety in order to oversee and monitor the trends and themes within this area.

Members noted that incidents related to alcohol-related conditions amounted to 9% of recorded incidents, although this still related to 458 incidents. In response to a question from Dr Benton, Mr Fleming advised that clinical and other staff did involve patient carers, relatives and peers when dealing with incidents relating to patients with learning difficulties. He advised that recording of violence and aggression incidents did incorporate hate crime incidents. Lastly, he gave an explanation on the use of safe restraint when the restraining of patients was necessary, and explained that training in this area was regularly held within Mental Health Services, and refresher training offered to staff. All incidents of restraining a patient were recorded.

(c) Reducing Carbon Emissions and Energy Consumption

There was submitted a paper [Paper No 14/117] by the Interim Director of Facilities which updated the Committee from the position described in the September 2014 paper and provided additional detail on the difficulties in meeting the current HEAT target which, for energy, was the reduction of 3.5%, however, the position within NHSGGC was that 3.14% more energy had been consumed. In addition, the carbon target was to achieve a reduction of 10.2%, however, the actual position showed an increase of 14.46%. The projections for the next two financial years would see the NHS Board also fail to meet these targets.

The current HEAT target (fossil fuel) campaign ended this year and the 2014/15 year would be used as the revised baseline for the next five years. There were no current plans with the appropriate investment profile which would deliver the levels of reduction in the NHS Board's carbon footprint during this financial year and when the new South Glasgow University Hospitals campus was to be handed over to the NHS Board next year, the NHS Board's footprint would increase by circa 2,500 tonnes.

Steps had been taken to introduce carbon reduction projects in relation to a biomass boilerhouse at the Royal Alexandra Hospital; Gartnavel oil to gas project and a CHCP biomass scheme. This would reduce the carbon footprint by around 71 tonnes. In addition, when the Western Infirmary, Royal Hospital for Sick Children, Victoria Infirmary and Mansionhouse Unit closed and the demolitions currently being undertaken at the Southern General Hospital occurred, this would contribute a further 119 tonne reduction.

Mr Calderwood enquired about the investments made in the NHS Board's estates since 2009 and, in particular, meeting the BREEM standards, but

this was not shown in the figures presented. Mr Gallacher, representing the Interim Director of Facilities, advised that the energy efficiency measures were a small part of the BREEM standards and whilst agreeing that the investments in new buildings had led to more energy efficient buildings, they were, unfortunately, more energy intensive by being bigger and offering additional services. Mr Calderwood acknowledged this, particularly around the significant increase in linear accelerators, however, it would be important to show the impact of that investment in future papers and also to undertake these discussions with SGHD when targets were being set. Mr Gallacher did intimate that discussions were being held with SGHD in order to try and make future targets in this area more realistic.

Interim Director of Facilities

Members, while being disappointed that these important targets were being missed, acknowledged that the level of investment necessary would be difficult to achieve and believed that it was important to influence SGHD in setting future targets which were achievable and acknowledged investments in new energy efficient buildings which offered additional and better service. It was noted, however, that while infrastructure was important, there were other, key messages for staff in and around behaviours within the workplace and these should be encouraged and additional awareness sessions and publicity issued to encourage staff to save energy wherever possible.

Interim Director of Facilities

NOTED

151. SHIFTING THE BALANCE OF CARE FOR OLDER PEOPLE

There was submitted a paper [Paper No: 14/122] by the Nurse Director updating members on the Older People in Acute Hospitals inspection activity and setting out the findings of the recent inspection of Inverclyde Royal Hospital in August 2014.

Three unannounced inspections had been held; one in Gartnavel General Hospital (October 2013); one in the Victoria Infirmary (April 2014) and the last one in Inverclyde Royal Hospital (August 2014). There had been a total of nine inspections in NHSGGC including two pilot inspections and Table 1 of the report set out the detail of these inspections.

The report concentrated on the inspection of Inverclyde Royal Hospital, setting out against each of the key headings the areas of strength and areas for improvement.

Mr Archibald presented the paper in the absence of the Nurse Director and, in responding to the Convener's question, advised that the feedback was given immediately after the inspection to senior managers who had an opportunity to ask questions during that session and then feed back themselves to the clinical staff. The feedback given at that time had been positive and the message was that staff had been very caring.

Members agreed that many strengths were identified by the inspectors, however, a consistent theme was the need to accurately, legibly and consistently record many aspects of the patient's care and whilst the NHS Board's auditing had suggested that this was an area of improvement, external scrutiny such as this inspection, did not support this view. Mr Archibald acknowledged the difference between the internal and external scrutiny processes and would look further at improving the current internal auditing process as this had been a disappointing aspect of the

Chief Officer, Acute Services

Older People's inspection.

NOTED

152. NATIONAL PERSON-CENTRED HEALTH AND CARE COLLABORATIVE – STRATEGIC REPORT AND WORK PLAN

There was submitted a paper [Paper No: 14/124] 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 eighth report highlighting the work undertaken within NHSGGC under the National Person-Centred Health and Care Collaborative. It described the progress made locally with the pilot improvement teams in clinical services within NHSGGC. Following discussions at the last meeting, the format of presentation had been altered to take into account Members' comments and the revised presentation of the information was welcomed.

Mr Finnie intimated that he was pleased by the positive feedback provided from patients' experiences and Ms Micklem welcomed the benefits staff were finding in reporting matters that then brought about changes and improvements in the care of patients.

NOTED

153. FOOD, FLUID AND NUTRITIONAL CARE UPDATE

There was submitted a paper [Paper No: 14/125] by the Nurse Director providing an annual update in relation to the implementation of Food, Fluid and Nutritional Care across NHSGGC. Ms Anna Baxendale, Head of Health Improvement, attended to present the paper in the absence of the Nurse Director and advised that significant progress had been made in relation to compliance with the National Food in Hospital catering standards and best practice identified within the revised Healthcare Improvement Scotland Food, Fluid and Nutritional Standards. She did, however, acknowledge that the consistent delivery and documentation at ward level continued to be challenging. She also drew Members attention to the fact that the Cabinet Secretary announced yesterday that the standards were intended to become statutory following the current public consultation process.

Over recent years, the NHS Board had invested significantly in the catering review and the two catering production units with a process of centralised production and localised meal regeneration. During this period, the NHS Board had consistently achieved 99.6% compliance with Food in Hospitals standards. Monitoring and patient feedback had also improved, however, recent media attention and the difficulty in meeting patients' expectations in catering had led to the proposal to develop a catering strategy for the NHS Board. This would include a focus on three outcomes of catering process which required to be optimal to ensure the highest quality food provision to patients.

Ms Micklem welcomed the report and was pleased that there was a proposal to develop a catering strategy. She was interested in whether a waste audit was undertaken and the results of such an audit would be considered within the strategy. Ms Micklem also requested that environmental aspects of catering were considered within the strategy. In response to Dr Benton's enquiry, Ms Baxendale indicated that it was indeed the case that it was important to manage the risk of achieving the

exact texture of the food presented for particular patients and having the confidence in the quality when delivered to the patients at ward level and work to explore potential in house production was underway. She acknowledged Mr Winter's point that the experience of Board Members had been that the food regenerated within the catering production units was fine but ensuring it reached patients within wards at the same remained challenging.

A full range of nutritional diets and a wider range of items on the menu was desirable together with an additional range of options in key clinical specialties and for patients in longer stay wards. Members acknowledged their visits to the catering department and were pleased with the food presented however, fully understood the challenges ahead in consistently maintaining a good and improved catering standard for all patients across NHSGGC.

NOTED

154. DIGNITY AND RESPECT: DEMENTIA AND CONTINUING CARE VISITS

There was submitted a paper [Paper No: 14/128] by the Interim Director, Glasgow City CHP which provided a report on the NHS Board's capacity to respond to the recommendations contained within "Dignity and Respect", the report of the Mental Welfare Commission visits into dementia continuing care wards across Scotland. Ms Jill Carson, Adult Services Manager, attended to present the report and answer Members' questions.

The Mental Welfare Commission for Scotland visited a number of dementia continuing care facilities across Scotland in 2013 including six older people's mental health sites within NHSGGC; namely:-

- Rutherglen Nursing Home (Roger Park Unit) – South Sector
- Darnley Court Nursing Home (Fleming and Carmichael Units) – South Sector
- Gartnavel Royal Hospital (Tate and Iona Wards) – North West Sector
- Birdston Nursing Home – North East Sector
- Mansionhouse Unit (North and South 1 Wards) – Renfrewshire CHP
- Dumbarton Joint Hospital (Glenarn Ward) – West Dunbartonshire CHCP

In 2014, the Mental Welfare Commission published its report entitled "Dignity and Respect" which summarised the findings of the visits to the dementia continuing care facilities and a number of general recommendations were made, with NHS Boards being asked to report on performance on relation to implementing these recommendations. Ms Carson highlighted each of the recommendations and the position within NHSGGC. She advised that this paper would also be reviewed by the Older People's Mental Health Clinical Governance Group at its next meeting in December, and the sectors identified within the recommendations would be asked to provide an update on progress towards implementing the recommendations. In addition, the Older People's Mental Health Clinical Governance Group planned to hold a themed audit event early next year to review the audit activity and look at the results/action planning.

Ms Carson highlighted that the recommendation relating to the Mansionhouse accommodation could not immediately be met as the facility was transferring to the new South Glasgow University Hospital in the spring/early summer of 2015. In addition, the development of the clinical services strategy would be an important part of which accommodation was to be retained or moved/improved.

NOTED

155. FINANCIAL MONITORING REPORT FOR THE 6 MONTH PERIOD TO 30 SEPTEMBER 2014

There was submitted a report [Paper No: 14/129] by Interim Director of Finance that set out the NHS Board's financial performance for the four month period to 30 September 2014.

The NHS Board reported an overspend of £1.4m, broken down into £1.2m over budget within Acute Services and £0.2m overspend within Partnerships. It was forecast that a year-end break even outturn would be achieved. In relation to the anticipated figures at the end of October 2014, the overspend was predicted to be £1.3m.

NOTED

156. NEW SOUTH GLASGOW HOSPITALS DEVELOPMENT: PROGRESS UPDATE

There was submitted a report [Paper No: 14/130] by the Project Director – New South Glasgow Hospitals Project setting out the progress against Stage 2 (design and development of the new hospitals) and Stage 3 (construction of the adult and children's hospitals).

In addition the paper covered the key risk summary, compensation events summary, the car park completion strategy, the transport to the South Glasgow University Hospitals campus.

The Convener indicated that as part of this report there should also be a discussion on the Members' visit to the Clinical Psychiatry Inpatient Unit at the new Royal Hospital for Sick Children.

As at 10 November 2014, 190 weeks of the 201 week contract had been completed and the project remained within timescale and budget and the handover date was 26 January 2015. In addition the Energy Centre construction, progress had been maintained and Car Park 1 which would also be due for handover to the NHS Board on 26 January 2015. In order to test patient services and allow staff to familiarise themselves with the new ward layouts, a mock ward had been set up on level 5 of the adult hospital to provide such an experience. It consisted of 14 bedrooms, a ward office, senior charge nurse office, pantry, domestic services room and all these areas had been pre-equipped and scenarios within this mock ward had commenced in early November 2014.

The Teaching and Learning Centre remained on programme and on budget for completion by the end of May 2015. The new staff office accommodation also remained on programme and on budget for completion by April 2015.

Mr Loudon intimated that the contractors still had over 800 workers on site as the contract moved into its final stages. Third party testing, installation and commissioning of water systems were all underway and all aspects of the programme remained on timescale as work was now being planned to commission the new hospital's facilities from 26 January for a twelve week period.

Mr Ross advised that the project remained on budget and highlighted the risk movement summary (appendix 2) and spoke about the new compensation events which had been concluded since the previous report to Committee in September 2014.

Car Park Completion Strategy

As a result of the continual development of the site masterplan, the opportunity to construct an extension to the existing multi-storey car park had been explored, which would increase the number of spaces from 700 to circa 980. In addition, as a consequence of construction of the new office building, a new opportunity to undertake additional demolitions, it has been established that it would be possible to construct approximately 330 surface level car parking spaces and Mr Loudon spoke to his paper which summarised the likely cost of the planned works, the funding mechanism, the planning process and the procurement strategy.

It had been previously approved that the multi-storey car park extension would be a standalone competitive procurement process and negotiations would be undertaken with Brookfield Multiplex over the surface level car parking spaces. Mr Calderwood and Mr Loudon explained the funding proposals associated with the additional car parking and Mr Calderwood reminded members that an Outline Business Case would be submitted to the Committee identifying the detailed funding sources and would seek the Committee's formal approval to proceed with the Outline Business Case.

In summary, the funding mechanism would include the release of funds from the Residual Risk Allowance, small sums from the Teaching and Learning Centre and new office accommodation projects, the availability of additional sums from the contract and a small remaining balance may be required to be funded from the Board's General Capital Funds as a priority strategic investment in 2015/16.

Members were supportive of the approach being taken in relation to the provision of additional car parking spaces and would review the Outline Business Case once submitted to Committee in the new year. **Project Director**

Transport to South Glasgow University Hospitals Campus

Mr Niall McGrogan, Head of Community Engagement and Transport, attended to present to members the transport plans as part of the new hospital's On the Move communication exercise. A section had been created on Staffnet and set out five travel options for staff, including cycling and walking, public transport, park and ride, car share and car parking.

Mr McGrogan took members through each in detail and in particular, highlighted the dedicated public transport road on the hospital site leading to a public transport superstop at the front door of the new adult hospital and adjacent to the front door of the new children's hospital. This area was to be known as Arrival Square. The

area would have four bus shelters with real time information, seating and lighting, and accessible kerbing to ease boarding/alighting vehicles. In addition, as part of the planning agreement with Glasgow City Council, the NHS Board was making available £2.5m to secure some improvements to public transport serving the site. Strathclyde Passenger Transport kindly agreed to undertake the tendering and procurement process on behalf of the NHS Board. It was anticipated the new services would be commissioned to commence from early May 2015.

The NHS Board continued to work with Glasgow City Council, Renfrewshire Council and Strathclyde Passenger Transport to progress all elements of the Fastlink Project. This was a bus rapid transit scheme whereby road space is either allocated or prioritised for use by high quality buses. It was anticipated that the service would run on improved roads from the City Centre's three public transport interchanges out to the new hospital and on to Braehead. Not all aspects of the work had progressed, in particular the City Centre infrastructure works, the remodelling of Govan Subway and Bus Station and the route out to Braehead in time for the opening of the new hospitals. However, good progress was being made in other areas which should allow the service to commence in 2015, particularly the work in the west which was likely to be important in attracting bus operators to run services to Arrival Square and through the site.

Members welcomed the update on the proposed transport plans to serve the new South Glasgow University Hospital campus.

Visit to the National Children's Psychiatry In Patient Unit – New Children's Hospital

A number of Members had undertaken a visit to see the Child Psychiatry Inpatient Unit on the fourth (top) floor of the new Children's Hospital following concerns that had been raised at previous Quality and Performance Committee meetings about safety aspects of the location of this Unit.

Full risk assessments with the clinical staff were still to be undertaken and these would be key in planning and managing the use of the space with the children being cared for in this Unit.

Mr Fraser accepted that the risk assessments were still to be undertaken. He had enjoyed the visit and noted the separate entrance for the children accessing the Unit.

Dr Lyons had submitted written comments and had indicated that he felt that children and their parents should be involved in suggesting how to utilise the space between the glass partitions and the central banister. He had concerns about the roof garden and that staff would need to observe children, for safety reasons, which may then limit availability of access to the roof garden. He was concerned about the idea of a separate entrance and felt this worked against the integration of functions and overall he was not convinced that the siting of the Unit was appropriate.

Rev Dr Shanks commented that he had also visited the site and felt that due process had been carried out and that the Chief Executive had given explanations around that due process which included the involvement of clinical staff in determining the location of the site.

Mr Calderwood had advised that workshops had been held and the outcome had

been that incorporating the Unit into the new Children's Hospital had been agreed with the clinical team, the important part now was that the current clinical users were required to undertake a full risk assessment of the unit and put in place plans and protocols in its use, recognising the concerns that had been identified and those which they highlighted as part of the risk assessment process. Mr Stephen McLeod, Head of Specialist Children's Services, highlighted that the Unit was for 12 year olds and under and the Unit would have a high staff to patient ratio. The care in the Unit would be in conjunction with stays at home and attending school, and quite often the length of stay of a patient within this Unit was short.

The overall concerns remained for some members, however it was accepted that the clinical staff would work through their risk assessment work following the visit they had planned to the site in December and there would be a report back to the Quality and Performance Committee on the outcome of the risk assessments undertaken. **Project Director**

DECIDED

1) That the progress of Stage 3 (construction of the Adult and Children's Hospitals), the Teaching and Learning Centre and the new staff accommodation (office) building be noted.

2) That the car park completion strategy recommendations be approved. **Project Director**

3) That the developing transport plans to support access to the South Glasgow University Hospital campus be noted.

4) That the risk assessment to be carried out by clinical staff in the Child Psychiatry Inpatient Unit be undertaken and submitted to the Committee for information. **Project Director**

157. HUB PROGRAMME UPDATE

There was submitted a report [Paper No: 14/131] by the Head of Capital Planning which provided an update on the feasibility study process for health and care centres with a view to prioritisation in anticipation of funding from the Scottish Government Health Directorate (SGHD).

In April 2014, the feasibility study process for the prioritisation of potential partnership projects for revenue funding from the SGHD through the Hub model was undertaken. The programme provided professional resource to CH(C)Ps to investigate and explore proposals for investment in detail and to examine service delivery opportunities, project deliverability and financial viability. Initially, ten projects were assessed and scored by considering the weighted aspects of assessment of the estate (10%); patient experience (10%); local strategic fit (10%); deliverability (30%) and financial assessment (40%).

From this process, three projects emerged – health and care centres at Clydebank, Greenock and Parkhead. In September 2014, SGHD notified the NHS Board that up to £20m of capital equivalent would be provided for a further health centre. As a result, the process to date had to be revisited and updated in order to identify a clear priority for funding.

A healthcare planner was engaged to examine in further detail the service model for each proposal and to drive operational efficiencies through investigation and

challenge of baseline data. There was a high level of engagement with staff from the CH(C)Ps, GPs and practice staff, and all service leads involved in planning of the prospective new facilities. In determining the service profile for each new build, the activity data was interrogated in some detail using UK best practice benchmarking. This enabled the CH(C)Ps to test out with service users the planned activity, efficiencies and room utilisation in each facility. Each potential project was then reassessed using the original scoring and weighting system and at that stage, Parkhead Health and Care Centre was eliminated from the process as the timescale for delivery of the project was outside the parameters for this cycle of the programme.

This led to a revised scoring for Clydebank and Greenock which ranked Greenock Health and Care Centre in the final consensus scores ahead of Clydebank.

The NHS Board's electronic asset management system advised that to bring the existing Clydebank and Greenock Health Centres to an acceptable level over the next ten year period would require £4,073,193 for Clydebank and £4,980,656 for Greenock.

The total capital required to deliver each project which covered the site costs, furniture and equipment and sub-debt investment was estimated as:- Clydebank - £1,990,978 and Greenock - £2,249,407.

In relation to the annual revenue implication for each project, this was estimated as follows:- Clydebank - £37, 895 per annum additional costs and Greenock - £68,804 per annum reduction in costs.

Mr Curran presented the summary update on the feasibility studies for Clydebank and Greenock and took members through the detail of each scheme.

The Convener advised that Members had received a copy of Councillor Martin Rooney's letter dated 17 November 2014 to the Chief Executive in which he raised a number of points in relation to aspects of the feasibility study and scoring and advised that Councillor Rooney believed the Committee should scrutinise the report and then refer the matter to the NHS Board for decision. Councillor Rooney would also be submitting a motion calling for the Scottish Government to commit to providing funding support to allow both Clydebank and Greenock Health Centres to progress.

Dr Benton, who reminded members that she was the Deputy Chair of West Dunbartonshire CH(C)P, queried the health and safety assessment and also the stated fact that there were no public objections to the location of the new Clydebank Health and Care Centre, and therefore, questioned if this would make a difference to the scorings. Mr Curran advised that there were health and safety/asbestos concerns with both current health centres. He agreed that no formal stakeholder engagement had been undertaken thus far, and it would be during that process that any issues would be highlighted one way or another in relation to the proposals. The Outline Business Case would cover these issues.

Mr Daniels commented that he did not believe this report was for noting and that due consideration should be given to the points raised by Councillor Rooney in his letter dated 17 November 2014 to the Chief Executive.

Ms Micklem enquired about the scoring/weighting which had identified the financial aspects at 40% but the local strategic fit at 10%, and wondered if this was following a national model. Mr Curran advised that the weightings had been

determined between January and April 2014 with the CH(C)Ps locally and had not been influenced by any national system/model.

Members went through, in detail, Councillor Rooney's comments in relation to health and safety/asbestos; the high score against the risk of public opposition to the site for Clydebank, however, to date there had been no opposition voiced; there was widespread support for the new Clydebank Health Centre ranging from the public, local councillors, MPs and MSPs; the risk of additional abnormal costs arising in respect of the Greenock scheme and, that the score for Clydebank should be influenced by the fact that the site was flat and remediated and that the Council had committed £15m towards the regeneration of the Queen's Quay; the regeneration work at Queen's Quay and the adjacencies which would be developed as Queen's Quay site became the civic heart of Clydebank; the commitment by West Dunbartonshire Council to identify an area within Queen's Quay equivalent to £2.5m, available at no cost to the Board, to build the proposed Clydebank Health Centre replacement; the likely connections that would be made with much-needed capacity to facilitate the delivery of the Board's Clinical Services Review objectives within the Clydebank area; the heavy weighting of finance which appeared to show that the Clydebank scheme might appear less financially attractive however, as the figures were estimates, both the capital and revenue figures were well within the margins of error; and lastly, the need to utilise this opportunity now to see the development of the new Clydebank Health Centre as it could be some years before the NHS Board had access to appropriate capital/revenue funding to commit to such a scheme in the future.

Councillor McIlwee intimated that he valued officers' commitment to the process which had been undertaken since April 2014 and he would not wish to undermine any other projects under consideration and the process agreed should be allowed to run its course.

Mr Sime supported this view and reminded Members that they had been asked to note the process to date, not to make any decisions and the NHS Board had clear arrangements for delegating the approval of Outline Business Cases to the Quality and Performance Committee. Mr Winter supported this view.

Mr Calderwood appreciated that this was a difficult situation where the funding was not available for both, very worthy and very much desired projects. He had chaired the meeting with Mr Curran and the two CH(C)P Directors in agreeing the criteria and he hoped that the paperwork submitted to the Committee showed the rigour in the process to date and the key part was now the development of the Outline Business Cases. He also acknowledged that the needs of Parkhead needed to be considered again in future to ensure that the appropriate range of services was available to that community.

Rev Dr Shanks felt that the discussion around Councillor Rooney's points had been fulsome and helpful, however, the process and transparency of that process had been fair and it was important that the Committee noted the position to date and awaited the development of an Outline Business Case.

The Convener summarised the outcome of the discussion that, overall, despite some Members considering that there should be a decision on which centre should be chosen for an OBC to be prepared, the Committee agreed to note the feasibility study process and would receive the submission of an OBC in due course for the Committee's approval based on the process.

Woodside Health Centre – Stage 1

Mr Curran provided an update on the development of Woodside Health Centre and following liaison with Glasgow City Council, the preferred site was Hinshaw Street, which was centrally located for the local population who would utilise the service and also had excellent public transport links.

However, a stage 1 report had been submitted by Hub West of Scotland on 8 October 2014, and this had highlighted a substantial increase in the cost from that originally agreed at the new project stage in May 2014. This increase was almost wholly attributable to costs for site abnormals and inflationary movement. SGHD advised that the funding gap would need to be filled by a capital contribution from the NHS Board. The options were to build in a capital contribution of £2.4m to the Capital Plan in 2016/17 or reduce the accommodation requirements to fit the current budget. The additional costs had been examined and deemed reasonable by the NHS Board's technical advisors, and in discussions, the Committee supported the option of building in the capital contribution of £2.4m to the Capital Plan in 2016/17. **Head of Capital Planning**

Inverclyde Adult and Older People's Mental Health

Mr Curran's update paper reminded Members of the intention of seeking delegated authority from the Quality and Performance Committee to approving the Final Business Case to allow it to be considered by the Capital Investment Group on 20 October 2014. Unfortunately the procedure for how this project was to be contractually delivered had been changed and the Full Business Case was not required to be submitted to the Capital Investment Group in October 2014. Subsequent to the last meeting of the last Quality and Performance Committee, a directive from the Scottish Futures Trust outlined a different approach as to how this project should be bundled with the Eastwood and Maryhill contracts. This now required the use of a high value change mechanism and necessitated the alteration of some 50% of the original documentation and required the approval of the funder, Aviva. Hub West of Scotland and their advisors were now examining the implications of this change in the programme to financial close, the content of the Final Business Case and costs, and an update would be provided to Members at the next meeting.

DECIDED

1) That the content of the paper, together with the revised feasibility scoring for both Clydebank and Greenock Health and Care Centres, be noted. **Head of Capital Planning**

2) That the progress report on the Woodside Health Centre project be noted and it was agreed to build a capital contribution of £2.4m into the Capital Plan in 2016/17 to support this project. **Head of Capital Planning**

3) That the update on the Inverclyde Adult and Older People's Mental Health project be noted. **Head of Capital Planning**

158. QUARTERLY REPORT ON CASES CONSIDERED BY THE SCOTTISH PUBLIC SERVICES OMBUDSMAN:-

(a) 1 APRIL – 30 JUNE 2014

(b) 1 JULY – 30 SEPTEMBER 2014

There was submitted two papers [Paper Nos: 14/133a and 14/133b] from the Nurse Director setting out the actions taken by the responsible operational areas in response to recommendations made by the Scottish Public Services Ombudsman in investigative reports and decision letters.

NOTED

159. ANALYSIS OF LEGAL CLAIMS – MONITORING REPORT (MID-YEAR REVIEW 2013/14)

There was submitted a paper [Paper No: 14/134] by the Head of Board Administration providing an overview of the handling and settlement of legal claims within NHSGGC in the 12 months from 1 October 2013 to 30 September 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.

NOTED

160. MEDIA COVERAGE OF NHSGGC SEPT-OCT 2014

There was submitted a paper [Paper No: 14/135] by the Director of Corporate Communications highlighting outcomes of media activity for the period September – October 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

161. BOARD CLINICAL GOVERNANCE FORUM MINUTES AND SUMMARY OF MEETING HELD ON 27 OCTOBER 2014

There was submitted a paper [Paper No: 14/136] enclosing the minutes of the Board Clinical Governance Forum meeting held on 27 October 2014.

NOTED

162. UPDATE ON CAPITAL PLAN 2014-15 TO 2016-17

There was submitted a paper [Paper No: 14/137] by the Chief Executive setting out the progress against the planned capital projects.

NOTED

163. 2013-14 ANNUAL REVIEW: SCOTTISH GOVERNMENT FEEDBACK LETTER AND ACTION NOTE

There was submitted a paper [Paper No: 14/138] by the Chief Executive providing the Committee with the SGHD letter setting out the outcome of the NHS Board's 2013-14 Annual Review. The letter summarised the main points discussed and the actions arising from the review.

NOTED

164. DATE OF NEXT MEETING

9.00am on Tuesday 20 January 2015 in the Board Room, JB Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH.

The meeting ended at 1:30pm