

DRAFT

QPC(M)13/01
Minutes: 1 - 20

NHS GREATER GLASGOW AND CLYDE

**Minutes of the Meeting of the
Quality and Performance Committee at 9.00 am
on Tuesday, 15 January 2013 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	Ms R Micklem
Ms M Brown	Cllr J McIlwe
Mr P Daniels OBE (Minutes 4(c) to 19(a))	Mr D Sime
Mr I Fraser	Mrs P Spencer BEM (to Minute 18)

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

Dr J Armstrong	Mr R Finnie
Mr R Calderwood	Mr P James
Ms R Crocket	Mr A O Robertson OBE

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

Ms J Gibson	..	Head of Performance and Corporate Reporting (to Minute 9)
Mrs J Grant	..	Chief Operating Officer
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director, Glasgow CHP
Mr A Mathers	..	Clinical Director, Women and Children's (for Minute 18)
Ms C Renfrew	..	Director of Corporate Planning & Policy (to Minute 14, and 19 -20)
Mr D Ross	..	Director, Currie & Brown UK Limited (for Minute No. 19)
Ms H Russell	..	Audit Scotland
Mr A Seabourne	..	Director, New South Glasgow Hospitals Project (for Minute No. 19)
Mr R Wright	..	Director, Health Information & Technology

1. APOLOGIES

The Convener wished everyone a happy new year and congratulated Mrs P Spencer on the award of her BEM for services to nursing in the New Year's Honours List.

Apologies for absence were intimated on behalf of Cllr M Kerr, Cllr A Lafferty, Mr B Williamson and Mr K Winter.

2. DECLARATIONS OF INTEREST

Declarations of interest were raised in relation to the following agenda items to be discussed:-

Item 4(c) – Local Authority Residential Beds – Inverclyde: Cllr J McIlwee

Item 4(d) – West Dunbartonshire CHCP – Update on Care Inspectorate Scrutiny Report: Ms M Brown

Item 19(b) - Approval of Outline Business Case – Joint Teaching and Learning Facility: Mr P Daniels

3. MINUTES OF PREVIOUS MEETING

On the motion of Mrs P Spencer and seconded by Ms M Brown, the Minutes of the Quality and Performance Committee Meeting held on 20 November 2012 [QPC(M)12/06] were approved as a correct record.

NOTED

4. MATTERS ARISING

(a) Rolling Action List

NOTED

(b) Western Infirmary - Site B and Embedded Space: Update

In relation to Minute 108(b) – Western Infirmary - Site B Update - Mr Calderwood advised the Committee that he was due to meet representatives of the University of Glasgow that afternoon with a view to concluding the last aspects of the disposal of Site B and the embedded space to the University in line with the terms set out in the paper submitted to the Committee in September 2012.

He agreed to report back to the Committee in May 2013 on the outcome.

Chief Executive

NOTED

(c) Inverclyde Council Commissioned Services for Specialist Nursing Care, Older People's Dementia and Adult Mental Health Intensive Supported Living Services

In relation to Minute 108(c) – Contract for NHS Partnership Beds and Local Authority Residential Care Beds - Inverclyde – there was submitted a paper [Paper No. 13/02] from the Director of Glasgow City CHP updating the Committee on the current position on the commissioning by Inverclyde Council/CHCP of specialist nursing care for older persons with dementia and adult mental health intensive supported living services in Inverclyde.

It had been proposed that Inverclyde Council and NHSGG&C separately commission the elements of service needed to meet their individual requirements. This decision was informed by two unsuccessful attempts to jointly procure from the market place a viable 74 bed contract. NHSGG&C was in the process of procuring 42 NHS mental health continuing care beds (30 for

older persons and 12 for adults) as had been outlined in the original procurement specification.

Inverclyde Council's service elements of the original tender had been reviewed and a needs analysis had determined that 12 older people mental health/dementia beds and up to eight adult mental health beds were required to be commissioned. Councillor McIlwee advised that Inverclyde Council had approved the recommendation to commission these services from the independent sector through a tendering process. This was for the provision of specialist nursing care services for older people specifically who had dementia and chronic functional mental illness such as schizophrenia or treatment resistant depression.

The procurement of the NHS mental health continuing care beds on the Inverclyde Royal Hospital site would see a submission made to the Scottish Government's Capital Investment Group at the end of February 2013. This would seek confirmation of capital funding and would either be through a capital allocation or the Scottish Futures Trust West Hubco arrangement.

Mrs Hawkins highlighted to Members that a bridging investment would be required for the additional period of time Ravenscraig Hospital would require to stay open. This would allow Inverclyde Council to progress their commissioning arrangements and have a suitable provider in place prior to the closure of Ravenscraig Hospital.

Ms Brown sought more information on the strengthening of the community infrastructure for older people's mental health services. In particular to the risks of the proposals, especially if the replacement services were not in place within the right timeframe, discussions stalled on the bridging finance required between both organisations or in relation to the resource transfer arrangements. Mrs Hawkins agreed that the next report back to the Committee will clearly identify all the risks associated with the proposals. She also advised that the Partners for Change Programme was a local authority scheme which aimed at building local, positive relationships with the third sector and to collaboratively develop and implement a commissioning improvement plan.

**Director –
Glasgow CHP**

DECIDED:

1. That, the present position on the proposed way forward and commissioning arrangements, be noted and endorsed. The key timescales and bridging requirements would be determined by the outcome of the Capital Investment Group in February 2013.
2. That, the progress reports during the commissioned period on the progress of the NHS GG&C procurement process and the Inverclyde Council arrangements, be received.
3. That, the requirements for Inverclyde for bridging finance for a period of time prior to the closure of Ravenscraig Hospital to enable the Council to put in place the services they required prior to the closure date, be noted. NHS GG&C would work with Inverclyde Council to determine the amount of bridging finance required, along with an appropriate funding source to meet the transitional costs – this work to be completed within three months.
4. That the balance of the unallocated resource currently shown as £664,000 was dependent on the final cost of both the commissioned places and the continuing care bed provision and was subject to further discussion on final investment, to be noted.
5. That, the background and context section of the paper setting out the next steps for both NHS GG&C and Inverclyde Council, be noted.

**Director –
Glasgow CHP**

(d) West Dunbartonshire CHCP – Update on Care Inspectorate Scrutiny Report

In relation to Minute 118 – West Dunbartonshire CHCP – Review – Mrs Hawkins, Director, Glasgow CHP, advised that the Care Commission Scrutiny Report on Services provided by West Dunbartonshire CHCP had been sent to Members in December 2012 for information. The report had highlighted two areas of uncertainty in relation to governance and management support to staff. Three recommendations had been made and the West Dunbartonshire CHCP Committee would oversee the implementation of the Action Plan to implement these recommendations.

**Director – West
Dun CHCP**

The report had been positive in relation to the joint work of the CHCP and in particular to the joint organisational performance review arrangements and the requirement to report back to both the NHS Board and Council on the outcome.

NOTED

5. INTEGRATED QUALITY AND PERFORMANCE REPORT

There was submitted a paper [Paper No. 13/03] from the Head of Performance & Corporate Reporting setting out the integrated overview of NHS Greater Glasgow and Clyde's performance.

Of the 42 measures which have been assigned a performance status based on their variance from trajectory, 28 were assessed as green; 11 as amber (performance within 10% of trajectory) and 3 as red (performance 10% outwith meeting the trajectory). The areas of key performances changes since the last report included:-

1. Sickness absence had moved from red to amber;
2. New outpatients; maximum 12 weeks from referral had moved from red to green
3. Ante-natal care had moved from green to amber

At the Committee's request the bed days lost to delayed discharge measure was disaggregated to highlight:- (i) the overall bed days lost to delayed discharges (including adults with incapacity); (ii) bed days lost to delayed discharges excluding adults with incapacity and, (iii) bed days lost to delayed discharges for adults with incapacity.

The Convener asked in relation to Accident and Emergency waiting times if more up-to-date information could be made available especially when there were particular challenges. The integrated Quality and Performance report was an organisational performance report and on this occasion the report had been prepared two weeks in advance due to the festive holiday period. Ms Renfrew advised that for future meetings that where performance has changed since the time the report was produced the relevant lead Director would provide the Committee with a verbal update.

Directors

In relation to Accident and Emergency waiting times, Mrs Grant advised that it had been a challenging period over the last four weeks due to the unprecedented demand on services and this had led on occasions to some hospitals failing to meet the agreed targets. While this was still variable most hospitals were now returning to an acceptable level of performance. The opening of additional bed capacity had been helpful and there had been a need to reduce the number of elective procedures in order to cope with the significant increase of emergency admissions. Mr Calderwood advised that he had written to those staff involved to thank them for

their significant efforts in meeting this increased demand on services over the last four weeks.

Mr Daniels enquired whether the 26 week target for faster access to specialist services (CAMHS) would be achieved by February 2013. Ms Renfrew advised that 16 patients were waiting over this time within Inverclyde. However all had been offered an appointment in January 2013. It was hoped that this would ensure the target was met and new referrals from 1 January 2013 would have a waiting time target of less than seven weeks. The Quality and Performance Committee's focus on the CAMHS services and the lengthy waiting times had been particularly helpful in bringing about improvements to the services for these patients.

NOTED

6. DEVELOPMENT OF LOCAL DELIVERY PLAN 2013/14

There was submitted a paper [Paper No. 13/04] from the Director of Corporate Planning and Policy setting out the SGHD guidance to NHS Boards on producing Local Delivery Plans (LDPs) for 2013/14. Three new HEAT targets had been included:-

1. Dementia – a minimum of one year's post-diagnostic support through a link worker for new people diagnosed with dementia including a person-centred support plan. This target would be due for delivery by 2015/16;
2. Healthcare Associated Infection – to further reduce the levels of staphylococcus, aureus, bacteraemia (including MRSA) and clostridium difficile;
3. In-Vitro Fertilisation (IVF) - eligible patients to commence IVF treatment within 12 months by March 2015.

The dementia and IVF targets would have substantial resource implications and these were currently being assessed.

The paper highlighted the NHS role in community planning and in particular the LDP included a requirement for Boards to indicate through their contribution to the Single Outcome Agreements the tangible contributions they will make in 2013/14 towards improved outcomes in;

1. Economic recovery and growth
2. Employment
3. Early Years and Early Intervention
4. Safer and stronger communities
5. Offending
6. Health Inequalities
7. Physical Activities
8. Older People

NHS Boards were required to submit their draft LDPs to SGHD by 15 February 2013 and final LDPs by 15 March 2013. Ms Renfrew will circulate a copy of the draft LDP – 2013/14 to Members for information.

**Director of
Corporate
Planning and
Policy**

Ms Micklem was interested in the increased emphasis on community planning engagement and Mr Calderwood advised that the NHS Board had no single approach

to community planning. NHS Boards were invited by Local Authorities to contribute to the community planning processes and it was very much driven by Local Authority priorities. Normally NHS Boards and Local Authorities did not have co-terminus boundaries and this could add to some of the difficulties however the NHS Boards and the CH(C)Ps played an active part in the community planning processes across the six Local Authorities within the NHS GG&C and where it had worked well the NHS Board had been an effective contributor. It was recognised that the NHS would feed in health priorities but it was also important what the NHS take out and learn from the community planning processes and contribute around some of the wider areas discussed.

Mr Finnie enquired about the process of developing new HEAT targets. Mr Calderwood advised that where strong clinical support and engagement was possible this was particularly helpful in influencing new targets, particularly, as Dr Armstrong highlighted, in relation to healthcare acquired infection rates. It was important to continue to try and ensure greater clinical engagement in the setting of future targets. Dr Armstrong highlighted the greater tolerance rate available down south with the 4-hour accident and emergency target set at 95% as opposed to 98% within Scotland.

The HEAT targets reflected the priorities of SGHD and it was important that NHS Boards and staff worked towards achieving the target set in order to contribute to the overall Board's performance. There was an important balance in securing investment monies from the national efficiency targets to support developments and new targets and one of the challenges was to continue to gain the support of staff and the communities in identifying and driving through further efficiencies. The importance of continuing an open dialogue between the NHS Board and SGHD was recognised in trying to shape appropriate priorities and investment decisions.

Ms Micklem highlighted that the guidance indicated the NHS Board should outline any risks which the delivery of a particular target could create in unequal health outcomes for people with protected characteristics and Ms Renfrew advised that this was underway and the opportunity would be taken to respond to SGHD as requested.

NOTED.

7. ORGANISATIONAL PERFORMANCE REVIEWS

There was submitted a paper [Paper No. 13/5] from the Head of Performance and Corporate Reporting setting out the detail of the mid-year Organisational Performance Reviews (OPRs). The paper highlighted an overview of some of the key achievements and issues which emerged from the mid-year OPRs. Ms Gibson would circulate to Members with a copy of the Inverclyde CHCP performance overview.

Ms Micklem asked about the read across from the corporate themes to the detailed discussions and performance overviews of the individual CHCPs/Acute Services Division. Ms Renfrew advised that the two hour OPRs looked at all commitments and targets and discussed all issues including the corporate themes in significant detail. The write-up of each performance overview would not necessarily cover all corporate themes if they had not been a priority within that particular area. However Members were assured that each corporate theme was discussed with each CHCP/Acute Service Division during their OPRs. Ms Renfrew agreed to submit the paperwork which supported the OPR process for Members' information.

**Director of
Corporate
Planning &
Policy**

NOTED.

8. ANNUAL REVIEW - OUTCOME

There was submitted a paper [Paper No. 13/6] from the Director of Corporate Planning and Policy which attached the letter from the Cabinet Secretary for Health and Wellbeing summarising the discussions and actions agreed at the NHS Board's Annual Review on 26 November 2012. The letter contained a number of actions and the Quality and Performance Committee would be kept up to date on the progress of implementing each of these actions.

Mrs Spencer had felt that the reports produced for members of the public were not conducive to easily understanding the issues being discussed. She had had first hand experience of this by sitting with two members of the public at the last annual review. Ms Renfrew advised that SGHD set out the format and type of paperwork however whilst further suggestions would be made to SGHD on the presentation of this annual public event NHS Board Officers would consider the production of a more public-friendly summary for those attending future annual reviews.

NOTED.

9. MEDIA COVERAGE – NOVEMBER/DECEMBER 2012

There was submitted a paper [Paper No. 13/7] from the Director of Corporate Communication highlighting the outcomes of media activity for the November/December 2012 period. The report supplemented the weekly media round-up which was provided to NHS Board Members every Friday afternoon and summarised media activity over the last few days and provided an alert for some issues which may be reported in the immediate future.

Members welcomed this report and particularly asked that the Director of Corporate Communications and his staff be thanked for the very helpful weekly media round-up.

NOTED

10. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2012

There was submitted a paper [Paper No. 13/8] providing the financial report for the eight month period to 30 November 2012.

The report showed an expenditure outcome of £0.3million in excess of budget for the first eight months of the year however it was considered that a year-end break-even position remained achievable.

Mrs Spencer asked a question in relation to the overspend within nursing pay and Mrs Grant advised that the Acute Director of Nursing was currently reviewing the position and meeting with each Directorate to review action plans and review the implementation of the workforce planning model. It had been the case that some additional bank and agency staff had been used in particular areas.

NOTED

11. SCOTTISH PATIENT SAFETY PROGRAMME REPORT

There was submitted a paper [Paper No. 13/9] by the Medical Director providing an

update on the acute adult core programme and the paediatric programme.

In relation to the two nationally set aims:-

1. to ensure that at least 95% of people receiving care do not experience harm – such as infections, falls, blood clots and pressure sores;
2. to reduce the Hospital Standardised Mortality Ratio (HSMR) by 20% by 2015.

The Medical Director advised that discussions were continuing with the SGHD over the definition of “harm” in relation to the first target. In relation to HSMR the latest release of the national SMR data to the quarter ending June 2012 indicated a national position of 0.89 with the Board achieving an overall trend across its acute hospitals of 0.84 – indicating a downward trend and an overall reduction greater than the national SMR figure.

The paediatric programme implementation continued within the Women and Children’s Directorate with the general ward workstream currently being spread beyond the pilot areas. All ward areas were actively engaged with hand hygiene and the children’s early warning score with a focus now on PVC and safety communications. Revised national aims from the Paediatric Action Group were awaited.

NOTED

12. INFECTION CONTROL SERVICE – HAI REPORTING TEMPLATE – JANUARY 2013

The was submitted a paper [Paper No. 13/10] by the Medical Director covering the Board-wide infection prevention control activity. The report was on an exception reporting basis only as the full report was submitted to each NHS Board meeting and this report covered the quarter July – September 2012.

The most recently validated results available demonstrated a staphylococcus aureus bacteria (SAB) rate of 27 per 100,000 average occupied days against a national rate of 29.3. The HEAT targets of 2010 and 2011 had both been achieved however more of these infections were being identified when patients were admitted from home or nursing homes and actions to prevent these were limited and would make the revised target of 26 cases difficult to achieve. The NHS Board rate for C.difficile infection for the quarter July – September 2012 was 17.4 per 100,000 occupied bed days which placed the NHS Board below the national average of 31.9 and well below the revised 2013 HEAT target of 39.

The NHS Board’s compliance with hand hygiene for the period 24 September to 5 October 2012 was 93% against the Scottish average of 95%. In relation to surgical site infection surveillance, all procedure categories, except reduction of long bone fracture, were on or below the national average. The purchase of an electronic surveillance model will facilitate broadening out surgical site infection surveillance to other operating procedure categories and this was welcomed.

Dr Armstrong highlighted from the paper the four superficial surgical site infections from cesarean sections carried out in August at the Royal Alexandra Hospital. A review had been undertaken of all cases and there was no common linking factors between the patients, however close monitoring would continue. In addition, four deep surgical site infections had been identified in October within orthopaedics at the

Royal Alexandra Hospital; three from hemi-arthroplasty and one knee joint surgery and all patients were on antibiotics as per the NHS Board's policy. Lastly it was reported that during November 21 wards across nine hospitals had been closed at some point to admissions due to norovirus and this figure had risen to 32 wards across 13 hospitals during December.

NOTED

13. CLINICAL RISK MANAGEMENT REPORT; SURVEILLANCE OF ADVERSE CLINICAL INCIDENTS

There was submitted a paper [Paper No. 13/11] by the Medical Director on Adverse Clinical Incidents. The reporting of Adverse Clinical Incidents had been displayed on two separate charts in order to highlight the position within Acute Services and separately within Partnerships.

Dr Armstrong highlighted the ongoing work in relation to the management of Significant Clinical Incidents (SCIs). NHS Board staff were currently engaging with Health Improvement Scotland to support their ongoing development of a national guidance framework for the management of SCIs. This had helped shape the national consultation document "Building a National Approach" which was launched on 8 January 2013. Contributions from members of the Committee would be welcomed and should be submitted to Mr Andy Crawford, Head of Clinical Governance by 15 February 2013 to enable a NHS Board response to be submitted.

Q&P Members

Health Improvement Scotland were also continuing their round of local inspection visits where they were auditing a small sample of Significant Clinical Incidents and interviewed both the clinical team and the investigation team for each case. No date has yet been set for the visit to NHS GG&C.

Within NHS GG&C clinical risk staff had been completing staff surveys and discussion groups to identify local perspectives on the SCI policy and process. Interviews had included patient forums and the information gained had been fed into a workshop with the key leads in each service. Steps were now being taken to review the collated information in order to revise the current policy and frame a set of outstanding issues which would be developed through a consultation process with the services. It was still intended to publish the policy in April 2013 however this depended on the publication of a national development framework.

Members welcomed the work ongoing within NHS GG&C and Ms Micklem enquired about the balancing of accountability and the promotion of a learning culture and in particular enquired about the training offered to the lead investigators for the SCIs. Dr Armstrong advised that root cause analysis training was available and this together with their experience of liaising with families had been particularly helpful. Mrs Spencer felt that the SCI process was variable across the NHS Board and that more focused training would certainly be beneficial for lead investigators, particularly in the role of sharing with families the details of significant incidents. Mrs Spencer agreed to submit comments in relation to the issues which had concerned her in relation to SCIs so that they could be considered as part of the consultation response from the NHS Board.

Dr Armstrong provided Members with the summary of the ongoing and completed Fatal Accident Inquiries and in particular drew Members' attention to the Sheriff's Determination that had been issued earlier this month in relation to Mr Hughes. The Determination stated that there were no reasonable precautions where the death may

have been avoided or were there any defects in any system of working. In relation to the escalation of phone calls to clinical staff and training for receptionists/telephonists, Mrs Hawkins would raise these with the Clinical Director to ensure that good practice was in place throughout NHSGG&C.

**Director of
Glasgow CHP**

Lastly Dr Armstrong highlighted a recent Freedom of Information request which had resulted in media headlines suggesting a higher mortality rate over weekends at the Royal Alexandra Hospital. In reviewing the information released it was found that it was based on a format that misrepresented the position. The number of patient deaths per weekdays and weekends were similar however in this instance mortality had been presented as a proportion of all discharges and this was inappropriate as it created a significant bias given the lower number of patients who were discharged at the weekend. The revised presentation of the information, provided in tabular form, did not provide any evidence of a real increase in mortality amongst those admitted at weekends. The review of processes for releasing information under Freedom of Information legislation had been undertaken to ensure that in future it was presented in a more balanced manner.

NOTED

14. CLINICAL GOVERNANCE IMPLEMENTATION GROUP MINUTES AND SUMMARY – 10 DECEMBER 2012

There was submitted a paper [Paper No. 13/12] in relation to the Clinical Governance Implementation meeting held on 10 December 2012 together with a summary report highlighting key issues. Dr Armstrong highlighted the error which had occurred with electronically transmitted discharge letters from North East Glasgow to GPs. A GP had highlighted that the paper copy of the discharge letter and electronic copy did not match and immediately a review was undertaken. This had highlighted an error in the system which involved the comment section and medication section. This was rectified and a review was undertaken to identify all records of patients involved and revised documentation was provided to GPs. No patient had come to harm however it had been a concern and the lessons learned from the review had been considered across the NHS Board.

The move from hard copy to electronic transmission of discharge letters was still ongoing and Mr Wright, Director of Health Information and Technology, advised that this process continued to be ongoing and that the errors in the electronic discharge letters had ensured an additional level of review of such important patient information. It had been clear that there had been no user acceptance part of the process and that would be the area which Mr Wright would further review and strengthen in future.

The issues in relation to the breakdown in relationships between clinical staff and Castlemilk Health Centre was ongoing.

NOTED

15. REPORT OF THE CHAPLAINCY SERVICE – 2012

There was submitted a paper [Paper No. 13/14] from the Director of Rehabilitation and Assessment Directorate setting out for information the Annual Report on the Healthcare Chaplaincy Services. The report highlighted the significant aspects of the year's work, identified priorities for service development and improvement and informed on the work of the healthcare chaplains.

NOTED

16. STAFF GOVERNANCE COMMITTEE MINUTE – 8 NOVEMBER 2012 AND REVIEW OF REMIT

There was submitted a paper [Paper No. 13/15] setting out the Staff Governance Committee minutes of its meeting held on 8 November 2012 together with the review undertaken by the Committee of its remit.

Mr Daniels asked for more information on the suggestion of Non-Executive Directors aligning themselves to specific Board-wide campaigns. Ms Brown, Chair, Staff Governance Committee, advised that the idea had been intended to be similar to the Non-Executive Directors' involvement in the leadership walk-arounds within Acute Services and it was hoped it would be a helpful contribution and involvement of Members in Board campaigns ie the recent homophobia campaign.

DECIDED:

1. that the Staff Governance minutes of its meeting on 8 November 2012 be noted.
2. that the Staff Governance remit be approved.

**Director of
Human
Resources**

17. PENSIONS – AUTO ENROLMENT

There was submitted a paper [Paper No. 13/16] from the Director of Human Resources setting out the background to the UK Government scheme for pension auto-enrolment which had been launched in October 2012 together with identifying the costs associated of introducing the scheme within NHS GG&C from 1 January 2013.

Membership of the NHS occupational pension scheme, administered by the Scottish Public Pensions Agency, was available to all employees within the NHS Board. All new starts who were eligible under the scheme's regulations were automatically included in the relevant section of the scheme on commencement unless they completed a form to opt out. Currently there were approximately 7,500 employees within the NHS Board who had exercised their right not to be a member of the scheme – this was largely within the paybands of 2, 3 and 5. Under the new arrangements employers must commence implementation of the new obligations by a date determined by the number of staff in the employer's PAYE scheme. This would be 1 January 2013 for the NHS Board although a transitional period, was available under the UK rules of 30 September 2017.

A sub-group of the Area Partnership Forum had been formed to oversee auto-enrolment and had met on two occasions. The preferred option of the group was not to take advantage deferring the auto-enrolment until 2017.

In relation to additional costs, if all existing staff who were not members of the scheme chose to join the additional costs to the Board would be £16 million per annum; if 50% joined the additional costs would be £8 million per annum.

Mr Sime emphasised the importance of staff to having adequate pension arrangements in place long before they retired, as this would help sustain independent living and he had supported the implementation of auto-enrolment from

2013. Mrs Spencer asked about the awareness of staff to the scheme and what steps would be taken to communicate with staff about the new arrangements and highlighting the benefits of contributing as early as possible to a pension. Mr Reid indicated that further discussion would be ongoing with the Area Partnership Forum and that communications would be prepared for existing staff and new starts to advise on the UK-wide scheme and provide encouragement to staff to join the pension scheme.

DECIDED

That the pension's auto-enrolment arrangements for existing staff at 31 March 2013, be approved.

Dir of Human Resources

18. MATERNAL MORBIDITY – ANNUAL REPORT

There was submitted a paper [Paper No. 13/13] from the Clinical Director for Obstetrics and Gynaecology providing an overview and perspective from NHS GG&C of the Health Care Improvement Scotland 8th Annual Report on the Scottish Confidential Audit of Severe Maternal Morbidity; Reducing Avoidable Harm.

Dr Alan Mathers, Clinical Director for Obstetrics and Gynaecology was welcomed to the meeting and gave a presentation on the findings of the 8th Annual Report and NHS GG&C's position with regard to the report and its recommendations.

Dr Mathers advised that a significant change would take place in the immediate future with regard to the processing of Scottish data relating to both maternal morbidity (ill health and survival) and maternal deaths. This was in response to a change in the UK-wide clinical outcome review programmes and a change to the previous UK Confidential Enquiry into Maternal Deaths. It was expected that it would be possible in future to extract and analyse Scottish data to be used as part of the new maternity safety and early years collaborative improvement programmes which were run under the auspices of Health Improvement Scotland.

The 8th Annual Report repeated many findings from previous years:-

1. Major obstetric haemorrhage remained the commonest cause of severe morbidity in pregnancy
2. Guidelines for the management of major obstetric haemorrhage were not followed consistently
3. The care of major obstetric haemorrhage was assessed by local reviewers as sub-optimal in one; five cases
4. Only 59% of cases of major obstetric haemorrhage were reviewed by maternity units' risk management teams
5. The quality of data collected varied and was poor from sub-units.

Dr Mathers took Members through each of the report's recommendations and "room for improvement" and presented the position within NHS GG&C.

The variation in the reported experience of each NHS GG&C consultant-led units remained consistent with the pattern and explanations provided last year to the Quality and Performance Committee. Two units were within the funnel of the national average performance for severe maternal morbidity and the unit at the Southern General was below the low threshold. It had been ascertained that this had been in relation to lower reporting levels arising from case ascertainment problems which had now been resolved.

Ms Micklem sought clarification of the statement within the Annual Report about the suggestion that there was no association between the level of deprivation and the occurrence of severe morbidity – recognising numbers were small and required to be aggregated for a number of years to be meaningful. Dr Mathers advised that the level of deprivation was indeed a factor.

Dr Benton asked about the impact of the move towards mothers giving birth at a later stage in their life. Dr Mathers indicated that the report highlighted some specific issues however it had been clear to him that the mothers giving birth, at a later stage of their lives, had different expectations from younger mothers. In relation to the data covering the period to 2010 Dr Mathers advised that there was indeed an inbuilt delay as much of the reporting was one year after any deaths and this was the nature of this type of data collection and national publication.

The Convener thanked Dr Mathers for his excellent presentation and report on this critically important area of the NHS Board's work.

NOTED

**19. NEW SOUTH SIDE GLASGOW HOSPITALS
(a) PROGRESS UPDATE – STAGES 2 & 3**

There was submitted a paper [Paper No. 13/17] from the Project Director of the Glasgow Hospitals Laboratory Project setting out the progress against Stage 2 (Design Development of the New Hospitals) and Stage 3 (Construction of the Adult and Children's Hospitals).

In relation to Stage 2 Mr Seabourne advised that the progress continued to be made in reviewing and agreeing the design of layouts and systems for the Adult and Children's Hospital. The next stage would be a move towards drawing up the programme of equipment installation requirements.

In relation to Stage 3, as at 6 January 2013, 93 weeks of the 112 week contract had been completed and the project remained within the timescale and within budget. Progress continued to be made on the construction of the new hospitals and Mr Seabourne provided further images highlighting the progress with both hospitals and in particular critical care, acute assessment, the ward wing, together with the mechanical and electrical area and energy centre.

In relation to community benefits, the project had recruited 257 new entry employees (exceeding the project target of 250) and this included 77 apprentices against a target of 88 for the project. In relation to the work experience targets, 160 placements had been provided against the target of 184 and overall the project was on track to achieve the training and recruitment targets ahead of schedule.

The design team was progressing the design detail for the construction of the new multi-storey carpark (carpark 1) and the agreed start of the one year contract was 29 April 2013. The compensation event for the multi-storey carpark would be concluded by the end of the week.

Mr Seabourne was pleased to advise that as part of the employers' requirements for the new Laboratory Medicine building the NHS Board had stipulated that the laboratory building design achieve BREEAM Excellent (Building Research

Establishment Environmental Assessment Message). Confirmation that the new Laboratory Medicine building had been awarded excellence status was confirmed by the Board's BREEAM consultant on 11 December 2012. The Committee congratulated Mr Seabourne and the project team on this excellent achievement.

Mr Ross took Members through the change control process, potential compensation events and provided an overall budget update. He highlighted that there had been one specific compensation event relating to ground contaminants discovered during excavations and this had been at a cost of £7,115.46. This was an area which may attract further changes as more groundwork was made available and investigated.

NOTED

Mr P Daniels left the meeting.

(b) OUTLINE BUSINESS CASE – TEACHING AND LEARNING FACILITY

There was submitted a paper [Paper No. 13/17b] from the Project Director of the Glasgow Hospitals and Laboratory Project providing Members with a copy for approval of the Outline Business Case (OBC) of the teaching and learning facility on the Southern General campus.

It had been recognised that to support the large modernised Southern campus the NHS Board in partnership with the University of Glasgow would benefit from a teaching and learning facility which would support their respective staff and students. The joint teaching and learning facility would replace the facilities on the Western Infirmary, Victoria Infirmary, Southern General and the Royal Hospital for Sick Children's sites. On completion of the new South Side Adult and Children's Hospital the site would comprise a new 1,109 bedded adult hospital; a 256 bedded children's hospital; a new laboratory building; maternity services, Institute of Neurological Sciences; the National Spinal Injuries Unit; Westmark (the rehabilitation technology service for the West of Scotland); elderly services and facilities for young physically disabled. There would be 10,000 staff and approximately 1,000 under-graduate and post-graduate students on the site, all requiring access to educational facilities to support their education training needs. Providing a joint teaching and learning centre on the Southern site would be the most effective way for students and staff to access these facilities.

The design of the new build had involved users from both the NHS Board and the University of Glasgow and both have signed off plans to Stage 3 – department adjacencies and departmental layouts. The timescale was to seek the Scottish Government Capital Investment Group approval of the Outline Business Case by the end of February 2013; target price agreed by the end of the July 2013 and seek final business case approval by the end of September 2013. If this proved to be the case the start on site would be November 2013 with an estimated completion date of May 2015.

The estimated capital costs had been derived from cost schedules produced by cost advisers and the joint teaching and learning facility would cost £20.3 million.

Whilst the agreed percentage split between both parties would be agreed before the final business case submission, currently the NHS share would be 48.5% - £9.844million.

Early discussions had taken place with SGHD officials prior to submission of the OBC to the Capital Investment Group and the three main comments highlighted had

been addressed within the OBC. The Convener had indicated that Mr Winter (who was on leave) had provided some written comments on this proposal. He supported the OBC and had asked about the control change process recognising this was a joint project between both the NHS Board and the University.

Mrs Grant indicated that the local user group would be the forum for any discussions and any changes from either party would be governed by the rules of engagement between the NHS Board and the University. As with the main hospital's contract it was intended to reach a stage where no further revisions would be accepted.

Mr Seabourne reported that a project manager had been appointed and in response to a question by Mr Robertson he advised that the selection process for the constructor and the designers had been undertaken via the Scottish framework process and therefore an open process had been undertaken leading, once the scheme had been approved, to entering a contract with BAM Construction for the full construction cost of the joint teaching and learning facility. The NHS Board would be responsible for managing all payments made to BAM Construction and would re-charge the University of Glasgow based on the agreed proportion of ownership with the University.

In relation to psychology services, discussions had not taken place with regard to those currently provided from Gartnavel Royal, however these could be discussed with the University at a meeting to be held that afternoon.

**Project
Director**

In relation to the impact on the balance sheet and the new building being subject to initial valuation by the District Valuer, the Convener had noticed that the OBC had commented that it was likely that the assessed value of the asset would be less than the capital spend and if so an impairment value would be calculated. This had been noted.

DECIDED:

That, the Outline Business Case for the joint teaching and learning facility with the University of Glasgow, be approved for onward submission to the Capital Investment Group of the Scottish Government.

**Project
Director**

20. DATE OF NEXT MEETING

9.00am on Tuesday 19 March 2013 in the Board Room, J B Russell House, Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow G12 OXH

The meeting ended at 12.30pm