

NHSGG&C(M)13/05
Minutes: 81 - 99

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 15 October 2013 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE	Councillor M Kerr
Ms M Brown	Councillor A Lafferty
Mr R Calderwood	Mr I Lee
Dr H Cameron	Councillor M Macmillan
Mr G Carson	Councillor J McIlwee
Ms R Crocket	Ms R Micklem
Mr P Daniels OBE	Councillor M O'Donnell
Councillor M Devlin	Dr R Reid
Prof A Dominiczak	Councillor M Rooney
Dr L De Caestecker	Mr D Sime
Mr P James	Mr B Williamson
Dr M Kapasi MBE	Mr K Winter

IN ATTENDANCE

Dr J Dickson	Associate Medical Director
Ms S Gordon	Secretariat Manager
Mr J C Hamilton	Head of Board Administration
Ms A Harkness	Director, Emergency Care & Medical Services
Mrs A Hawkins	Director, Glasgow City CHP
Dr G Penrice	Consultant in Public Health Medicine (For Minute No 89)
Ms C Renfrew	Director of Corporate Planning and Policy

ACTION BY

81. APOLOGIES

Apologies for absence were intimated on behalf of Dr J Armstrong, Mr R Finnie, Mr I Fraser and Rev Dr N Shanks.

NOTED

82. DECLARATION(S) OF INTEREST(S)

No declaration(s) of interest(s) were raised in relation to any of the agenda items to be discussed.

NOTED

83. CHAIR'S REPORT

(i) On 22 August 2013, Mr Robertson met with representatives from the Royal

Voluntary Service (RVS) where many matters were discussed including an enhanced emphasis on using the cash generated by the RVS on a service priority basis – this development was welcomed by the NHS Board.

- (ii) Throughout September 2013, Mr Robertson attended a number of staff recognition events including the launch of the Modern Apprenticeships, the SVQ Annual Awards Ceremony, an Inspiring City event, the launch of Project Search on 19 September 2013 and a staff event celebrating success in taking forward Facing the Future Together (FTFT) on 26 September 2013.
- (iii) On 2 and 3 October 2013, Mr Robertson attended an Institute of Health Management (IHM) conference at the Beardmore Hotel.
- (iv) On 11 October 2013, Mr Robertson met with staff from the Glasgow Centre of Population Health. He took the opportunity to commend the fantastic and varied work the Centre took forward.
- (v) On the evening of 14 October 2013, Mr Robertson attended the Leverndale Art Exhibition.
- (vi) Mr Robertson alluded to the flu vaccination programme well underway in the community and being promoted heavily to NHS staff to ensure they protected themselves and their patients from cross-infection. He invited NHS Board members to take the opportunity, following the NHS Board meeting, to have their flu vaccination.

NOTED

84. CHIEF EXECUTIVE'S UPDATE

- (i) On 5 September 2013, Mr Calderwood met with the Principal of the University of Strathclyde to discuss the University's input into health matters locally.
- (ii) Since the last NHS Board meeting, Mr Calderwood continued to be involved in a series of meetings with the Scottish Government Health Directorate (SGHD) and local authorities to progress the agenda on integration of health and social care.
- (iii) Mr Calderwood provided an update on the significant IT incident which occurred between 1 and 3 October 2013. This had been a software error on a computer server supporting a number of ICT systems in one part of the NHSGGC estate, meaning that a significant number of users were unable to access information that they needed to carry out frontline functions. The impact of this was significant on a number of levels and the incident underlined the importance of having arrangements in place when key information was not available from the usual digital sources. All of the 709 patients who had their procedures postponed had now been re-booked and he praised staff for their remarkable resilience shown in ensuring that more than 10,000 patients continued to be seen using manual back-up systems. He also thanked the NHS Board's IT team for their tireless round-the-clock work to get the system back on line. The Cabinet Secretary had commissioned a review of resilience relating to NHSGGC and other Health Boards which would result in a full investigation into the cause of the issue. This would be led by an independent team who would prepare a report into the actions taken by NHSGGC to address the problem so that lessons could be rolled out across the whole of NHS Scotland. The review and its recommendations would be circulated as soon as they were available.

NOTED

85. MINUTES

On the motion of Dr R Reid, seconded by Dr M Kapasi, the Minutes of the NHS Board meeting held on Tuesday, 20 August 2013 [NHSGG&C(M)13/04] were approved as an accurate record and signed by the Chair.

NOTED

86. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was noted.
- (ii) Councillor Rooney asked about progress made in taking forward the Clinical Services Review. Mr Calderwood reported that a paper would be submitted to the December 2013 NHS Board meeting confirming emerging themes. It was anticipated that, thereafter, a fuller report outlining options would be compiled and, at that time, this would require formal consultation. Mr Calderwood confirmed that any formal consultation phase was likely to be around three months with any recommendations being made, thereafter, to the Cabinet Secretary for approval.

**Medical
Director**

NOTED

87. SCOTTISH PATIENT SAFETY PROGRAMME

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 13/42] asked the NHS Board to review and comment on the ongoing progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Dickson led the NHS Board through a summary of recent activities in respect of the SPSP. He alluded to the significant shift in the strategy approach to evolving the Acute Adult Care Programme within SPSP as announced by the Scottish Government at the beginning of September 2013. The first major change was the announcement of "Patient Safety Essentials" which shifted the emphasis from testing and spread towards one of sustainable universal implementation which required approaches to ensuring and assuring the continued provision of interventions as standard work in all clinical areas. Before the transition to any new form of governance for the Patient Safety Essentials, it was important to recognise the current position regarding levels of spread across Acute Services and Dr Dickson provided an overview of this within each of the Patient Safety Essentials. In doing so, he acknowledged that the spread had already passed 90% in six of the nine elements. In general, the position reached was the point where the improvement work was concluded and there was an opportunity to think about different approaches to assuring maintenance of required process reliability and the Acute Services Division had already reviewed options for this to become a specified general management responsibility.

To this end, the NHS Board was expecting the publication of a new national measurement plan which was described as simplifying the data burden on clinical teams. The SPSP support team would work with the Acute Services Division management teams to ensure that any local measurement processes were consistent with national requirements. This proposal had been agreed, in principle, but still needed endorsement by the NHS Board's Clinical Governance Forum.

Mr Sime referred to the disappointing result for peripheral vascular catheters which currently sat at 72% compliance. Dr Dickson acknowledged this and explained that the supporting team had identified measurement problems that had created a lag in reporting. He was hopeful this would be improved in the next reporting period. In response to a further question from Dr Benton regarding this, Dr Dickson confirmed that this was the case, not just in NHSGGC, but consistently across the West of Scotland.

Ms Micklem welcomed the focus from improvement to sustainability but wondered how this would be monitored. Dr Dickson confirmed that the NHS Board's Quality and Performance Committee would consider, in governance terms, how sustainability would be measured going forward.

Dr Dickson took the opportunity to commend the Patient Safety Leadership Walkrounds that were ongoing and routine activity supported by Senior Leads in the Acute Services Division and by non-executive directors.

NOTED

88. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 13/43] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

Dr Dickson explained that the report represented data on the performance of NHS Greater Glasgow and Clyde on a range of key HAI indicators at national and individual hospital site level.

In 2007, the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to staphylococcus aureus bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. This target was extended once again, and NHS Boards were required to achieve a rate of 26 cases per 100,000 Acute Occupied Bed Days (AOBDs) by April 2013. For the last available reporting quarter (January to March 2013), NHSGGC reported 26.8 cases per 100,000 AOBDs. NHS Scotland reported 30.1 cases per 100,000 AOBDs. NHSGGC, therefore, failed to achieve the national 26 cases per 100,000 AOBDs target for 2013. This was the NHS Board's lowest AOBDRate to date and fourth lowest in total patient numbers. The revised national HEAT target required all NHS Boards in Scotland to now achieve a rate of 24 cases per 100,000 AOBDs or lower by 31 March 2015.

The national report published in September 2013 (reporting quarter January to March 2013) showed the rate of C.difficile within NHSGGC as 30.03 per 100,000 AOBDs in over 65s. This still placed the NHS Board below the national mean (31.7 per 100,000 AOBDs in over 65s). The revised HEAT target required Boards to achieve a rate of 25 cases per 100,000 AOBDs in **all** patients (previously, the target *only* included patients 65 years and over) to be attained by 31 March 2015.

For the last available quarter (April to June 2013), the surgical site infection (SSI) rate for all four orthopaedic procedure categories were below the national average, however, the rate for caesarean sections was above the national average although remained within the 95% confidence intervals.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 2,964

members of staff who were now registered as Cleanliness Champions.

In respect of hand hygiene, the latest information available, as at July 2013, recorded a figure of 93% compliance in NHSGGC.

Mr Williamson asked about the pilot in surgical site infection surveillance within large and small bowel surgery (performed at the Southern General Hospital) which commenced in February 2013. Dr Dickson reported that procedure numbers remained very small and involved a mixture of different colorectal procedures and inpatients with existing co-morbidities, therefore, local results were being interpreted with due caution. No further detailed analysis was available nationally due to the small procedure numbers in both categories but Dr Dickson agreed to discuss this matter with Dr Armstrong to identify if further information could be provided in future reports.

**Medical
Director**

NOTED

89. STAFF FLU VACCINATION PROGRAMME IN NHSGGC IN 2013/14

A report of the Director of Public Health [Board Paper No 13/44] asked the NHS Board to note the arrangements in place to offer flu vaccinations to all directly managed staff within the NHS Board area.

Dr de Caestecker explained that the Public Health Protection Unit had been working very closely with NHSGGC's Occupational Health Service since the 2010/11 flu season to deliver the annual flu vaccination programme to NHSGGC staff. Over the last two years, the uptake rate had improved from approximately 24% in 2010/11 to around 40% in 2012/13. This was still below the 50% target set by the Scottish Government, however, lessons had been learned over the last three years and it was hoped that NHSGGC could continue to build on the successes of the last few years and further improve its uptake in 2013/14. To do this, Dr de Caestecker reported that a multi-disciplinary planning group had been formed to coordinate and plan for the year 2013/14 and she outlined the main objectives and aims of this year's campaign. Dr Penrice added that there would be four modes of vaccination delivery to staff in NHSGGC including peer immunisation, mass vaccination clinics, roving teams and via appointments at the Occupational Health Department.

Councillor Rooney wondered what else could be done to increase the uptake of the flu vaccination with NHSGGC's staff to meet the 50% target. Dr Penrice referred to the intensive marketing strategy where she was working with the NHS Board's Corporate Communications Team and "Flu Champions" who were senior nurses and/or doctors within each hospital who could champion the seasonal flu vaccination locally. In response to a further question regarding the marketing strategy, she added that part of the communication would ensure all staff understood that their role, as healthcare workers, meant that they had a moral responsibility to have the flu vaccination to prevent putting others at risk. Mrs Brown hoped that the "myth busters" leaflet used last year for staff would be used again and Dr Penrice agreed to ensure this formed part of the marketing strategy.

Mr Sime wondered if temporary staff and/or students were eligible to take part in the NHS Board's local programme. Dr de Caestecker agreed to clarify this matter with the Occupational Health Department. In a similar vein, Professor Dominczak wondered whether medical students were aware of their obligation to have the flu vaccination and suggested that part of the communications campaign include an emphasis with that group of staff.

**Director of
Public Health**

NOTED

90. CHANGES TO HEALTH BOARD BOUNDARY

A report of the Director of Corporate Planning and Policy [Board Paper No 13/45] asked the NHS Board to note an update in respect of a change to the Health Board's boundary.

Ms Renfrew led the NHS Board through the update on progress towards the alignment of Health Board and Local Authority boundaries. Following the June 2013 announcement by the Cabinet Secretary for Health and Wellbeing, a Joint Steering Group from NHS Lanarkshire and NHSGCC was initiated with several key workstreams underway. The principal aim was to overcome the administrative barriers that misalignment presented to integrated working and ensure the areas affected became an integral part of the Adult Health and Social Care Integration process. She reported that the changes came into effect on 1 April 2014 and summarised the following key workstreams which had been established and reported to the Joint Steering Group:-

- Independent Contractors;
- E-Health;
- Property and Support Services;
- Directly Managed Services;
- Human Resources;
- Public Health/Health Improvement;
- Finance/Corporate;

All workstreams were working towards a deadline of December 2013 to complete the scoping of services and the identification of future transfer arrangements. Furthermore, a comprehensive financial framework was being developed for the project, outlining current service spends and performance trends along with the post-transfer resource requirements to ensure patients from the area were able to receive a fair and equable service in NHS Lanarkshire.

In response to a question from Mr Daniels, Ms Renfrew confirmed that both NHS Boards would need to engage with the Scottish Government to be clear how resources would be realigned to reflect the population changes and support the Boards if that realignment created financial pressures in one or other of the Boards. This would be reported to the NHS Board when it became clear.

**Director of
Corporate
Planning and
Policy**

Dr Benton referred to the groups of people with the greatest potential to be adversely affected by these changes, namely, older people and those with a disability. Ms Renfrew agreed and confirmed that the findings of the Equality and Diversity Impact Assessment would be utilised across the project workstreams to minimise identified risks. Thereafter, a risk matrix would be developed through the Project Steering Group with areas of concern reported in subsequent updates to the NHS Board.

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NOTED

91. WINTER PLAN 2013/14

A report of the Director of Emergency Care and Medical Services [Board Paper No 13/46] asked the NHS Board to note the current planning regarding unscheduled care and the additional planning in place for winter 2013/14.

Ms Harkness led the NHS Board through the background to preparing for winter in terms of planning for key risks/challenges and noted initiatives being taken forward to support winter planning and address areas of risk. National guidance on the preparation

of winter plans was issued on 26 September 2013 and covered issues such as resilience, unscheduled/elective care, norovirus, seasonal flu, respiratory pathway, management information, out-of-hours, governance and integration of key partners/services.

Following the service pressures over last winter, a review of that service was undertaken including feedback from frontline staff on lessons learned, learning from reviews of systems elsewhere and a system-wide review of the pattern and volume of admissions and attendances. This information was used to inform the NHS Board's local unscheduled care plan.

Ms Harkness explained that work with partners had focussed on escalation. As such, an escalation plan, setting out the response of the key organisations during the winter period and particularly during the festive period, with clear triggers for each status, had been revised and updated. As in previous years, the communications team would support the organisation's preparations for winter through the local and national winter campaigns. The team was liaising with Local Authorities to ensure their staff were aware of the festive season arrangements and could share this. Staff immunisation against flu had already started and had been discussed earlier. The programme for vaccination of vulnerable groups including children, by GPs had been set in place.

Mr Williamson asked about the additional beds opened during winter 2012/13. Ms Harkness clarified that some of the additional beds opened during this period had continued into the spring but reported they were now all closed. The Winter Plan 2013/14 allowed for the opening of additional beds if necessary.

Councillor Lafferty referred to the model used to reduce the number of patients waiting for discharge in East Renfrewshire which had worked well and had also identified ways to avoid hospital admittance. Ms Renfrew acknowledged the contribution made by local authority partners on this issue and confirmed that discussions were ongoing with CH(C)P Directors to identify best ways to tackle this longer term.

Councillor Kerr referred to the Scottish Government's target to ensure that 95% of patients be admitted or discharged from an emergency department within four hours of their attendance and wondered if this increased the likelihood of admission. Ms Harkness indicated that hospitals had developed assessment areas where patients who requested a longer period of assessment prior to discharge could be seen away from the Emergency Department.

**Director of
Emergency
Care &
Medical
Services**

On a related matter, Mr Robertson referred to the challenge to minimise the time patients spent in hospital and to promote alternatives to hospital attendance and admission that had the confidence of clinicians and service users. Dr Cameron agreed and acknowledged the actions identified to address these issues which would include additional allied health professionals providing services at weekends. There was a concern as to how this shift could happen within current available resources.

NOTED

92. CAR PARKING

A report of the Director of Corporate Planning and Policy [Board Paper No 13/47] asked the NHS Board to note the strategic approach to car parking.

Ms Renfrew referred to a number of discussions about car parking issues at the NHS Board and, more recently, a petition presented by residents adjacent to the Royal Alexandra Hospital in Paisley about issues caused by staff parking in residential streets. As such, she described the NHS Board's approach to managing car parking.

Ms Renfrew led the NHS Board through the four key strands of the NHS Board's car parking policy which was kept under review on each site by the Facilities Directorate who also tried to ensure that issues caused by staff parking around sites were raised with staff. With regard to the suggestion that the NHS Board should simply provide more car parking, Ms Renfrew stated that given the gap between available parking and staff numbers, marginal changes in spaces would not have a significant impact. In addition, the Board did not have available capital to prioritise and fund additional car parking and lastly, some new sites/developments had the number of spaces on hospital sites governed by planning rules.

Ms Renfrew acknowledged that car parking was a difficult issue, but that the NHS Board's current policy found the best balance between the interests of patients, visitors and staff.

In response to a question from Councillor Macmillan regarding "planning rules", Ms Renfrew confirmed that this referred to Local Authority planning rules. Local Authorities used a ratio criteria to determine the number of parking spaces and this was related to activity. She confirmed that the NHS Board worked with each Local Authority area to identify those numbers but that each had clear principles of the rules and regulations governing these and that each planning application was looked at on its own merit. With regard to the Royal Alexandra Hospital (RAH) site, Councillor Macmillan confirmed that Renfrewshire Council continued to be available to discuss the issues raised further in an attempt to achieve a solution for local residents, patients, visitors and staff. Mr Calderwood welcomed this approach and agreed that further discussions would take place.

**Chief
Operating
Officer**

Ms Renfrew explained that the paper described the NHS Board's strategic approach to car parking as a whole and her comments above had to be taken together and not in isolation. With particular regard to the RAH, she reported that it had a higher ratio of parking available than other NHSGGC site and, furthermore, a higher ratio of spaces available to staff.

Dr Reid enquired about disabled parking spaces and Mr Calderwood confirmed that NHSGGC knew exactly, site by site, how many spaces were available for disabled parking and confirmed that the Facilities Directorate regularly looked at the balance and, in particular, their location within a hospital site. Site staff kept their usage/under-usage under regular review. Mr Carson added, on this point, that 40% of buses in Glasgow and Glasgow's Underground were not accessible to many people with disabilities and he considered, therefore, that the NHS Board's target for the provision of disabled spaces should be higher, given the client group it served. Ms Renfrew accepted that if there were concerns around the usage of disabled spaces (and their appropriate use) this could be reviewed to ensure it was either fit for purpose or changes were required.

**Director of
Corporate
Planning and
Policy**

Councillor Lafferty welcomed the discussion at NHS Board level and recognised the conflicting pressures which made it all the more important to get right. Mr Calderwood agreed and confirmed that NHSGGC worked with each Local Authority as well as local public transport companies to ensure ease of access to sites. It was currently the case, however, that staff were declining to use many of the alternatives available and he confirmed his commitment to continue to work to resolve that. On that point, Councillor Kerr added that Glasgow City Council was due to commence a cycle hire scheme and it may be that the new Southern General Hospital campus site could accommodate one of the new cycle stations if that was helpful. Mr Calderwood welcomed the approach and agreed to discuss this matter further.

**Chief
Executive
Officer**

NOTED

93. DEVELOPING PRIMARY CARE: 17C CONTRACTS

A report of the Director of Corporate Planning and Policy [Board Paper No 13/48] asked the NHS Board to note work in progress to work with GPs to develop proposals to improve primary care.

Ms Renfrew explained that NHSGGC was limited at a local level to agree changes to the UK-wide General Medical Services (GMS) contract to only specific areas where there was flexibility to negotiate local service agreements. Almost all of NHSGGC's GP practices were currently on GMS 17j contracts which specified, in line with the national GMS contract, the essential services, additional services and a rigid structure which dictated payments to be made to the practice. Within the national contract, however, there was the option to negotiate 17c contracts. This enabled a GP practice and the NHS Board to agree what was provided and what the payment amount and requirements were – it could include or vary any part of the national contract.

To take this forward, a session with GPs took place at the beginning of October to gauge and discuss the potential of 17c contracts. Many issues were discussed and positive ideas raised on how GPs could change the way they worked if there was a more flexible contractual agreement. Many GPs present expressed real concerns about the challenges and pressures they faced in trying to provide the best care particularly for older people, patients with multi-morbidities and patients in the most deprived communities. It was clear that there were major issues with the current contract and many GPs were willing to positively engage with the NHS Board to consider the 17c alternative. Further work would be undertaken to progress this suggestion and Ms Renfrew agreed to keep the NHS Board up to date as this developed.

**Director of
Corporate
Planning and
Policy**

Dr Kapasi was supportive of this proposal and sought more use of the 17c contract but cautioned that it must be monitored effectively as, although the concept was good for patients, practices *must* deliver the services they indicated they would deliver in the national contractual agreement. Mr Williamson regarded this as excellent news for patient care and hoped that it would enhance trust and good relationships between GPs and the NHS Board.

NOTED**94. WAITING TIMES AND ACCESS TARGETS**

A report of the Chief Operating Officer [Board Paper No 13/49] asked the NHS Board to note progress against the national targets as at the end of August 2013.

Ms Harkness led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times/18 Weeks Referral to Treatment (RRT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. She also highlighted the number of patients awaiting discharge from hospital beds across NHSGGC.

Mrs Brown referred to the number of patients awaiting discharge and, in particular, the total patients delayed in the South Sector of Glasgow Community Health Partnership (CHP). Mrs Hawkins confirmed that the South was a more complex area due to the bigger spread of hospitals and challenges currently regarding social work interventions there. Glasgow City CHP continued to monitor this situation to seek improvements.

In response to a question from Dr Benton regarding the disappointing compliance at the Western Infirmary with the Accident and Emergency Waiting Times (which was 88% as

at August 2013; the target was 98% compliance with a length of time from arrival at A&E of four hours). Ms Harkness reported that this was recognised and some physical changes had been made at the A&E department at the Western Infirmary and it was hoped to reap the benefits of that change soon.

NOTED

95. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 31 AUGUST 2013

A report of the Director of Finance [Board Paper No 13/50] asked the NHS Board to note the financial performance for the first three months of the year.

Mr James explained that the NHS Board was currently reporting an expenditure out-turn £1m in excess of its budget for the first five months of the year. At this stage, however, the NHS Board considered that a year-end break-even position would be achieved. Mr James led the NHS Board through further information in relation to expenditure in Acute Services, NHS Partnerships and Corporate Services and included details of expenditure to date against the NHS Board's 2013/14 capital allocation.

Mr James reported that, during the next few months, the NHS Board would undertake a mid-year review to determine whether it remained on track to deliver a break-even outturn for 2013/14.

In response to a question from Councillor Rooney regarding the "top up" of £9m for auto-enrolment, Mr James explained where this was captured and clarified that it needed to be reinstated for the next year to ensure a recurring balance was in place.

Councillor O'Donnell noted the entry (Resource Transfer to Local Authority) as noted in the table referring to NHS Partnerships. There was only such an entry for Glasgow City CHP and he sought an entry for the non-Glasgow CH(C)Ps. Mr James agreed this would be included for future reports.

**Director of
Finance**

NOTED

96. MENTAL HEALTH (CARE AND TREATMENT) (SCOTLAND) ACT 2003: LIST OF SECTION 22 APPROVED MEDICAL PRACTITIONERS

A report of the Director of Public Health [Board Paper No. 13/51] asked the NHS Board to approve the list of Medical Practitioners employed by the NHS Board to be authorised for the purpose of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003.

DECIDED

That the seven Medical Practitioners listed in the NHS Board paper for the purposes of Section 22 of the Mental Health (Care and Treatment) (Scotland) Act 2003 be approved.

**Director of
Public Health**

97. AREA CLINICAL FORUM MINUTES: 1 AUGUST 2013

The Minutes of the Area Clinical Forum meeting held on 1 August 2013 [ACF(M)13/04] were noted.

NOTED

98. PHARMACY PRACTICES COMMITTEE MINUTES: 14 AUGUST 2013 AND 18 SEPTEMBER 2013

The minutes of the Pharmacy Practices Committee meeting held on 14 August 2013 and 18 September 2013 [PPC(M)13/04] and [PPC(M)13/05] were noted.

NOTED

99. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 17 SEPTEMBER 2013

The Minutes of the Quality and Performance Committee meeting held on 17 September 2013 [QPC(M)13/05] were noted.

NOTED

The meeting ended at 11.30am