NHSGG&C(M)09/1
Minutes: 1 - 27

NHS GREATER GLASGOW AND CLYDE

Minutes of a Meeting of the NHS Greater Glasgow and Clyde Board held in the Board Room, Dalian House 350 St Vincent Street, Glasgow, G3 8YZ on Tuesday, 24 February 2009 at 9.30 am

---

P R E S E N T

Mr A O Robertson OBE (in the Chair)

Professor D Barlow
Dr C Benton MBE
Mr G Carson
Dr L de Caestecker
Mr R Cleland
Councillor J Coleman
Dr D Colville (to Minute 13)
Mrs A Coulthard (to Minute 9)
Dr B Cowan
Ms R Crocket (to Minute 14)
Mr P Daniels OBE
Ms R Dhir MBE
Mr T A Divers OBE
Mr D Griffin
Mr P Hamilton
Dr M Kapasi MBE
Councillor D MacKay
Councillor J McIlwee
Mrs J Murray
Mrs R K Nijjar
Councillor I Robertson
Mr D Sime
Mrs E Smith
Mrs A Stewart MBE
Councillor A Stewart
Councillor D Yates

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

Mr G Archibald	..	Director of Emergency Care and Medical Services (to Minute 6)
Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Mr T Eltringham	..	Head of Health and Community Care, East Renfrewshire CHCP (to Minute 12)
Ms S Gordon	..	Secretariat Manager
Mr J C Hamilton	..	Head of Board Administration
Mrs A Hawkins	..	Director of Mental Health Partnership
Mr A Lawrie	..	Director of South Lanarkshire CHP (to Minute 16)
Mr N McGrogan	..	Head of Community Engagement and Transport
Mr A McLaws	..	Director of Corporate Communications
Mr I Reid	..	Director of Human Resources
Ms C Renfrew	..	Director of Corporate Planning and Policy/Lead NHS Director, Glasgow City CHCPs

ACTION BY

1. APOLOGIES

Apologies for absence were intimated on behalf of Mr J Bannon MBE, Councillor J Handibode, Mr I Lee, Mr G McLaughlin and Mr B Williamson.

2. CHAIR'S REPORT

(i) Mr Robertson had attended the Glasgow City Community Health and Care Partnerships (CHCPs) Management Team Event on 17 December 2008. This had been a successful meeting in terms of formalising the direction of travel for Glasgow City CHCPs and fine-tuning their Scheme of Delegation and Scheme of Establishment.

ACTION BY

(ii) Throughout January 2009, Mr Robertson had visited many hospital sites including the Princess Royal Maternity Hospital, Gartnavel Royal Hospital, Royal Alexandra Hospital, Blawarthill Hospital, Beatson West of Scotland Cancer Centre, Golden Jubilee National Hospital and Canniesburn Plastic Surgery Unit (Glasgow Royal Infirmary). Over and above this, he had also attended the formal openings by the Cabinet Secretary of Possilpark Health Centre, the Emergency Dispatch Function (based at Caledonia House), Plean Street Centre for Health and Care in Yoker and the Aroma Coffee Bar based at Glasgow Royal Infirmary.

(iii) On 29 January 2009, Mr Robertson had met with Professor Barry Gusterson (University of Glasgow) and on 16 February 2009, Professor Sir Michael Bond with whom he had discussed the fundraising appeal launched to fund the Beatson Translational Research Unit (the third element of cancer service improvement work and where there were direct links between research and patient care).

(iv) On 16 February 2009, Mr Robertson had participated in the "Industry Day for the South Glasgow Hospitals" at Hampden.

NOTED

3. CHIEF EXECUTIVE'S UPDATE

(i) Mr Divers had attended the launch of the staff survey results at the Beardmore Hotel on 21 January 2009. An action plan was being taken forward to address the issues arising from this.

(ii) On 23 February 2009, Mr Divers had attended the first part of the Scottish Government's annual gathering of public sector Chief Executives. This was chaired by the Cabinet Secretary for Finance and Sustainable Growth.

NOTED

4. MINUTES

On the motion of Councillor D Yates, seconded by Mr P Hamilton, the Minutes of the meeting of the NHS Board held on Tuesday, 16 December 2008 [NHSGG&C(M)08/8] were approved as an accurate record and signed by the Chair.

NOTED

5. MATTERS ARISING FROM THE MINUTES

The rolling action list of Matters Arising was circulated and noted.

NOTED

6. VISION FOR THE VALE OF LEVEN HOSPITAL : OUTCOME OF CONSULTATION

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 09/01] asked the NHS Board to receive the outcome of the Vale of Leven Hospital consultation process and the responses submitted and, thereafter, consider the recommendations contained within the paper.

ACTION BY

The NHS Board was also asked to note that plans for the Alexandria Medical Centre, which was a capital project, were being taken forward through a separate process for approval by the Scottish Government Capital Investment Group.

Ms Byrne set out the background to the consultation process in relation to the vision for the Vale of Leven Hospital site. She described, in detail, the engagement and consultation process that had been undertaken and provided a summary of the responses received, both in writing and at public meetings and drop-in sessions and highlighted the NHS Board's considered responses to this feedback.

She reminded the Board that the vision for unscheduled medical care that had been consulted upon was developed following the Independent External Review of Anaesthetics undertaken in July and August 2008. She summarised the conclusions of that review as follows:-

- 24 hour Anaesthetics provision was not sustainable on the Vale of Leven Hospital site.

- A GP led model of unscheduled medical care should be developed at the hospital.

Ms Byrne outlined the key proposals and explained that the impact identified by these changes on patient activity in the hospital was highlighted and had been included in the vision document and presented at public meetings.

Ms Byrne explained that similar themes had been raised in the written responses, public meetings and the drop-in sessions. She led the NHS Board through the six themes as follows:

- The vision and consultation
- Unscheduled medical care
- Stroke services and rehabilitation
- Mental health services
- Repatriation of planned care services
- Access and transport

She outlined the NHS Board's position on the responses received explaining that the recommendations translated the vision that was consulted upon for the Vale of Leven into a deliverable and realisable opportunity for the future. It would see a large increase in the number of patient episodes delivered on the site. Whilst there would be a reduction in inpatient bed numbers and an associated reduction in overall staffing numbers at the hospital, the NHS Board's Organisational Change Policies would be applied which ensured that there would be no compulsory redundancies required. The developments in relation to planned care would also provide new employment opportunities at the hospital.

Based on comments made during consultation, Ms Byrne made reference to the following points regarding the recommendations being made:

- It had been concluded that a Consultant led model of care, in which GP principals and GP specialty trainees would be key partners, represented the best model of care which could be sustained in future, without the requirement for anaesthetic support. The key elements of the model would see a Consultant Physician on site at the Vale of Leven Hospital throughout the day time period on Monday to Friday each week, with a post-receiving round of new admissions plus "troubleshooting" of any other ill patients taking place on a Saturday and Sunday. GP principals would lead the onsite medical cover provided outwith these periods and an innovative GP specialty training rota would anchor the junior/middle grade medical staff support.

ACTION BY

This model moved to address significantly the concerns and issues raised by the Physicians and the two Royal Colleges. For that reason, it was recommended that the NHS Board approve the development of that model of care which retained the majority of the current unscheduled medical care activity at the Vale of Leven Hospital without the provision of 24 hour Anaesthetic cover.

- The provision of much improved community and primary care mental health services over the last year and, in particular, the further extension of the crisis service from January 2009 had resulted in a significant reduction in the number of admissions to the Christie Ward. The current level of adult admissions ran at around twelve per month. This level of admissions was under the level anticipated for a twelve bedded ward. When the full impact of the improved community service was delivered, the number of admissions would reduce further, lengths of stay would reduce and it was anticipated that within 12 months there would no longer be a viable admission unit. Careful monitoring of the impact of community services would continue: it was expected that the Christie Ward would close within 12 to 18 months and the beds transfer to Gartnavel Royal Hospital.

- The proposals in relation to introducing new and expanded planned care services proved uncontroversial during consultation. These would require investment in the Vale of Leven site in terms of equipment and staff. It was recommended that the repatriation of these services in relation to planned care was approved by the NHS Board as an essential part of the wider vision and corresponding recommendations outlined. Similarly, it was recommended that the proposal to develop palliative care services at the Vale of Leven be approved.

If the NHS Board approved the recommendations outlined, they would be subject to a decision by the Cabinet Secretary. Following a discussion with the Cabinet Secretary, the next steps would be to develop a Capital Investment Plan for the hospital to ensure that services could be delivered from appropriate accommodation on an ongoing basis. It was anticipated that this Capital Investment Plan would be developed within nine months. As part of this Capital Plan, an overall vision for the physical layout of the site would be developed and this would incorporate the plans for the new Alexandria Medical Centre. In relation to timescales for implementing the changes described by Ms Byrne, a process of implementation would commence from no more than one year after a decision had been taken by the Cabinet Secretary.

Mr Robertson acknowledged the work of all those involved in progressing this consultation exercise to reach this stage. He particularly thanked Mr P Hamilton who had chaired all nine of the public meetings.

Councillor Robertson also recorded his thanks and welcomed the model and vision especially as it provided the local community with certainty over the future of the hospital. He did not agree, however, with the recommendation that would see the closure of the acute adult mental health admission service provided from Christie Ward.

In response, Mrs Hawkins noted that the average length of stay within the Christie Ward was much higher than other similar wards within NHSGGC. The figures had demonstrated usage of the Christie Ward was declining and this was to be expected as community services developed in the area. She reiterated the NHS Board's vision to maximise community services thereby minimising admissions to mental health services within any hospital.

She explained that there would be careful recording of the use and impact of local community and primary care services with regular reporting to the Clyde Modernising Mental Health Programme Board and the Mental Health Partnership Committee and this would inform the ultimate date of transfer of the existing Christie Ward service to Gartnavel Royal Hospital in twelve to eighteen months time. Mr P Hamilton welcomed this clarification and supported the recommendation.

Mr Divers confirmed that a reducing pattern of usage within the ward was already apparent and he was confident that the NHS Board could provide a safe and sustainable service in the community as local community services improved. Monitoring the declining usage would be key to establishing the ultimate closing date of the Christie Ward. He re-emphasised a point made earlier, in that it was important to bring certainty to the community regarding the totality of the vision and to be clear about what services would be provided at the Vale of Leven Hospital longer term. As such, it was important to conclude now that the Christie Ward would not remain viable beyond the short term.

Councillor MacKay welcomed the work that had been carried out in setting a positive scene and future for the Vale of Leven Hospital. He noted that the "north of the river" option had been explored thoroughly as this had been raised at many of the public meetings. It was concluded that this was not a practical or deliverable solution either financially or in staffing resource terms. He asked whether a further public consultation would be required in two years time if the NHS Board did not today make a decision on the acute adult mental health admission service provided from Christie Ward. Mr Divers confirmed that this would indeed be the case and it was acknowledged that this would add uncertainty to the community rather than being clear about the NHS Board's intentions as they stood today.

Mr Carson commended the intention to maintain a stroke rehabilitation service at the Vale of Leven Hospital – to which patients would transfer as soon as it was clinically appropriate. This reflected the belief that it was desirable for rehabilitation to take place as locally as possible as soon as was possible. His comments were especially relevant as he referred to a recent newspaper article which ranked the Southern General Hospital Stroke Unit fourth in Europe for the number of patients treated this way.

In response to a question from Ms Dhir, Mr Divers confirmed that the plans for the Alexandria Medical Centre had been included within the document as, although it was a capital project being taken forward through a separate process for approval by the Scottish Government Capital Investment Group, it had been helpful in terms of highlighting service provision within the Vale of Leven Hospital campus and for illustrating the overall development plan.

It was anticipated that the new Alexandria Health Centre would be operational by late 2012/early 2013 and this would be discussed further at the Performance Review Group meeting held in March 2009.

In response to a question from Mr P Hamilton, Mr Divers confirmed that a commitment had been made to invest and improve the fabric of the Vale of Leven Hospital building. Work would also continue with the Scottish Ambulance Service to finalise the discussions about the resource implementations of meeting the additional patient journeys and conclusions would be reported publically.

Councillor Robertson moved an amendment to the recommendation concerning the acute adult mental health admission service currently provided from Christie Ward transferring to Gartnavel Royal Hospital in 12/18 months time. He suggested this be reworded to read as follows:

ACTION BY

"Accept the majority views expressed by the local community and other stakeholders through the consultation process and approve the retention of Adult Acute Mental Health Services within improved accommodation at the Vale of Leven Hospital as detailed in Option 1 of the consultation document. Acknowledge the commitment to continue to develop community based services. In addition, recognise the potential impact visiting relatives and carers may have on patients' recovery through increased accessibility of retention of local services at the Vale of Leven.

The NHS Board was also asked to note the concerns expressed by local GPs regarding a further one year delay in the provision of the new Alexandria Health Centre".

Councillor Robertson sought a seconder. No seconder was found, therefore, the proposed amendment fell. Councillor Robertson asked that his dissent be recorded in relation to the recommendation to close the Christie Ward in 12/18 months and transfer the service to Gartnavel Royal Hospital.

DECIDED - Subject to Councillor Robertson's dissent as noted above :

- That the outcome of the consultation process and responses submitted be received.

- That the conclusion from the consultation (and two earlier external reviews) that the level of Anaesthetic Service required to support the current model of unscheduled medical care was not sustainable be approved. — **Director of Acute Services Strategy Implementation and Planning**

- That the development of alternative arrangements for the provision of unscheduled medical care at the Vale of Leven Hospital that would sustain approximately 70% of the current activity without the continued provision of anaesthetic cover be approved. — **"**

- That alternative arrangements for the provision of local rehabilitation services be approved. — **"**

- That the retention of elderly acute admission mental health services at the Vale of Leven site and their integration with continuing care mental health services currently housed in Dumbarton Joint Hospital be approved. — **"**

- That the closure of the acute adult mental health admission service provided from Christie Ward with the transfer of this service to Gartnavel Royal Hospital in twelve to eighteen months time be approved. That there be careful monitoring of the use and impact of community and primary care services with regular reporting to the Clyde Modernising Mental Health Programme Board and the Mental Health Partnership Committee and this would inform the ultimate date of transfer. — **"**

- That the repatriation of 18,350 planned care attendances in relation to Urology, Ophthalmology, Rheumatology, Renal Dialysis and Oral Health Services to the Vale of Leven site and the future development of a palliative care service be approved. — **"**

- That the recommendations be submitted for decision by the Cabinet Secretary for Health and Wellbeing be noted.

- That the plans for the Alexandria Health Centre, which was a capital project and being taken forward through a separate process for approval by the Scottish Government Capital Investment Group be noted.

ACTION BY

7. REVIEW OF NHS CONTINUING CARE FOR FRAIL ELDERLY

A report of the Chief Executive and Director of Rehabilitation and Assessment [Board Paper No 09/02] updated the NHS Board on the discussions and contact with St Margaret's of Scotland Hospice since the NHS Board meeting in April 2008.

Mr Divers outlined the background to the review of planning for frail older people and explained that the planning assumptions regarding frail elderly continuing care beds remained valid and there remained more NHS continuing care beds in use than were required to meet the needs of the population. As such, it was recommended that the NHS Board agree to the further reduction in NHS continuing care beds proposed at St Margaret's and in South Glasgow.

The proposed redevelopment of Blawarthill was a holistic service solution to the needs of residents of West Glasgow including social and disabled housing and additional care home beds of which there was a shortage in that sector of the city.

It had been suggested that the NHS beds at Blawarthill should be closed or used for these different types of care. To use these beds as social care would leave the NHS beds isolated and difficult to staff safely and would also lead to a disproportionate number of social care beds in that part of the city. The suggested shift of NHS continuing care of older people with mental health problems to St Margaret's was made in recognition of St Margaret's desire to stay as a provider of NHS care. It was not part of the NHS Board's extant mental health strategy and was proposed specifically as a means to find an acceptable way forward with St Margaret's.

Mr Divers explained that to close thirty NHS beds at Blawarthill would require further public engagement and consultation. Most particularly, it would involve the NHS Board moving away from the decision to which it was committed following public consultation in 2000 and abandoning the commitment it had made to develop the Blawarthill site in conjunction with the key partners. There was no need nor justification to move away from that decision taken in 2000 – it remained the appropriate strategic decision for the years ahead.

The current accommodation at Blawarthill was, however, largely in shared rooms whereas St Margaret's was able to provide mainly single room accommodation. It was, therefore, recommended that the redevelopment of Blawarthill continue and that the transfer of responsibility for continuing care frail elderly services from St Margaret's be linked to the opening of the new 100% single room accommodation at the hospital. St Margaret's would be given formal written notice with terms linked to that development, which was expected to be available early in 2012.

Mr Divers commented that St Margaret's was fundamentally opposed to considering any option for change other than an expansion of the hospice beds. They did not consider that providing care beds with nursing to be compatible with their core values and maintenance of their hospice status.

As part of its palliative care planning, the NHS Board was currently concluding a needs assessment regarding palliative care for non malignant conditions. This would form part of the NHS Board's response to the recently launched National Action Plan for Palliative and End of Life Care in Scotland. St Margaret's proposed expansion of inpatient beds required to be viewed in light of that piece of work and in the context of other NHS Board priorities for this type of care. It was, therefore, not possible for the NHS Board to respond to the proposal at this stage.

ACTION BY

The proposal also had significant implications for other specialist palliative care providers and would require detailed discussion with them and other relevant clinicians. Planning for palliative care was conducted through the Managed Clinical Network. It was, therefore, recommended that the proposed expansion in palliative care beds be considered by the Managed Clinical Network for Palliative Care as part of its ongoing response to "Living and Dying Well".

Mr Divers confirmed that the NHS Board would continue to work with St Margaret's to encourage them to consider options for development should the palliative care proposal not be pursued - in order to ensure that the facilities there continued to be available for the population and to ensure that the current level of palliative care was not jeopardised.

In this regard, Mr Robertson confirmed that he had met with the Chairman of St Margaret's on 19 February 2009 and St Margaret's continued to decline to take part in any assessment of a move to a different model of care other than their proposed expansion of palliative care.

In response to a question from Mr Cleland, Mr Divers confirmed that St Margaret's position was that they wished to retain wards for palliative care development only and, as such, were not prepared to enter into discussions regarding the other options. In commending the work that was undertaken at St Margaret's Hospice, Ms Dhir was disappointed that St Margaret's was not prepared to collaborate as a partner in rejecting consideration of the proposals made by the NHS Board.

For the avoidance of any doubt, Ms Renfrew highlighted two different strands of work, namely, the future of palliative care and NHS continuing care. She explained that both were not contingent on each other - rather they had separate processes and interdependences as described earlier.

Councillor Stewart referred to paragraph 6.1 of the Board paper showing the indicative financial impact of the options. For Option 1, it was her understanding that the NHS Board was being asked, under the recommendations, to issue formal notice to St Margaret's that the NHS Board would not require St Margaret's to provide NHS continuing care once the new wards at Blawarthill Hospital were open in 2012. It was her view that, at present, the NHS Board did not know if option 4 "Additional Palliative Care" was a viable option until the NHS Board concluded a needs assessment regarding palliative care for non malignant conditions and had detailed discussions with specialist palliative care providers and other relevant clinicians. Furthermore, she noted, the NHS Board had received thirty-five written representations from the public and the Scottish Government Petitions Committee a petition of over 100,000 signatures. Councillor Stewart commented that this demonstrated the strength of feeling of the public to secure the future of St Margaret's. She concluded by adding that if the NHS Board agreed to the recommendations, St Margaret's and the public would be entering into a period of uncertainty and this would cause further concern.

It was noted that Mr Bannon had submitted comments for information and consideration

Councillor Stewart moved a motion to delay the decision-making until all the detailed work for Option 4 was completed in order that all viable options could be fully considered. The motion was seconded by Councillor Robertson. A vote was, therefore, conducted as follows:-

- In favour – 3 Board members
- Against – 20 Board members

The motion fell and the NHS Board decided the following:-

ACTION BY

DECIDED:

- That the implementation of the shift in the balance of care be continued be agreed. **Director of Rehabilitation and Assessment**
- That the NHS Board's commitment to the redevelopment of Blawarthill Hospital site be reaffirmed. **Director of Rehabilitation and Assessment**
- That the outcome of the recent discussions with St Margaret of Scotland Hospice Board be noted.
- That formal notice to St Margaret's that the NHS Board would not require St Margaret's to provide NHS continuing care once the new wards at Blawarthill Hospital were opened, targeted for early 2012 be issued. **Director of Rehabilitation and Assessment**
- That the issue of St Margaret's expanded provision of palliative care within the thirty beds currently designated for continuing care should be considered by the Managed Clinical Network for Palliative Care as part of the NHS Board's ongoing response to "Living and Dying Well" be noted. **Director of Rehabilitation and Assessment**

8. HEALTHCARE ASSOCIATED INFECTION – C.DIFF ACTION PLAN

A report of the Medical Director [Board Paper No 09/03] asked the NHS Board to note the latest update on the NHSGGC action plan and the follow-up review report from the Independent Review Team.

Dr Cowan recounted that the NHS Board had previously reviewed the on-going progress against the recommendations set out in the initial report from the Independent Review Team. One of the key recommendations was that the Review Team undertake a further review six months after the initial review. This further review took place during December 2008 and January 2009 and Dr Cowan led the NHS Board through their report which had been published on 10 February 2009.

Dr Cowan explained that the specific actions had been split into the following key areas:-

- Governance
- Facilities
- Clinical Leadership
- Surveillance
- Education
- Communication
- Finance

In relation to the follow-up report by the Independent Review Team, it confirmed that the recommendations had been systematically addressed by the NHS Board and monitored through monthly progress reports. As such, a much improved and more direct organisation for the control of infection was being implemented and would be fully integrated with the rest of the NHS Board's area by March 2009 – supported by a number of key appointments.

In response to a question from Mrs Nijjar, Dr Cowan confirmed that the dress code guidance had followed national guidance.

NOTED

ACTION BY

9. HEALTHCARE ASSOCIATED INFECTION

A report of the Medical Director [Board Paper No 09/04] asked the NHS Board to receive the first formal monitoring report on Healthcare Associated Infection (HAIs) within NHSGGC.

Dr Cowan explained that the Monitoring Report to the NHS Board was following a requirement of the National HAI Task Force Action Plan and the report presented data on the performance of NHSGGC on a range of key HAI indicators at national and individual hospital site level.

Dr Cowan outlined the NHS Board's position and performance in relation to:-

- S. aureus bacteraemias (HEAT Target)
- C.difficile
- Surgical site infections
- Hand hygiene compliance
- Monitoring of cleaning services.

Dr Cowan led the Board through the data as it was presented at both national and hospital level and summarised the following points:-

- If current trends were maintained, NHSGGC would achieve the target of a 35% reduction in S. aureus bacteraemia by 2010.

- The National Report published on 14 January 2009 showed that NHSGGC was below the national mean and that there had been a reduction of C.difficile in 2007/2008. The annual overall rate for NHS Scotland per 1000 occupied bed days was 1.29. The rate for NHSGGC was below this and was reported as 1.08 for the same time period.

- The Surgical Site Infection rates in NHSGGC were below the national average for all procedures reported apart from hip arthroplasty.

- NHSGGC had demonstrated a steady rise in compliance during the national audit periods from a 62% baseline in February 2007 to achieve the 90% target in September 2008 and 92% in January 2009.

- All areas within NHSGGC scored green (>90%) in the most recent report on the National Cleaning Specification.

Mr Sime referred to hand hygiene compliance and noted, in particular, the disappointing rate for medical staff. Dr Cowan responded by confirming that although compliance was lower for this group of staff, work was ongoing to raise awareness and to ensure hand hygiene was being addressed fully at Local Governance meetings. Professor Barlow recognised that there were different styles and practices across the medical professions, be it surgeons or physicians. Given that physicians were often a non invasive profession, it was important to also ensure compliance within this group of staff. It was paramount to change ways of working and, in this regard, Professor Barlow referred to a new module delivered by Universities to all medical students to address this subject.

Dr Colville asked how this would impact on primary care and Dr Cowan confirmed that healthcare associated infection monitoring would include primary care and, as such, a strategy would be distributed throughout General Practice shortly. Dr Colville welcomed this and commented that an increased length of stay in any hospital increased chances of infection and acknowledged that when a patient left hospital any infection often disappeared quickly.

Medical Director

ACTION BY

In response to a question from Mr Cleland, Dr Cowan confirmed that a survey was underway concerning visitors/members of the public and their compliance with hand hygiene.

NOTED

10. WINTER PLAN 2008/09

A report of the Director of Acute Services Strategy Implementation and Planning [Board Paper No 09/05] asked the NHS Board to receive an update on Winter Planning 2008/09 including a progress report on how the plan had worked over the extended festive period and into the New Year.

Ms Byrne confirmed that, given the extreme pressures on acute services, NHS 24 and GP Out of Hours Services in the early part of December 2008, it was felt that NHS Greater Glasgow and Clyde performed well over the festive period. There were two contributing factors she wanted to highlight:

(1) The recent co-location of NHS 24, Out of Hours Services and the Scottish Ambulance Service at Caledonia House.

(2) Working together, across the system, in the pre-winter period.

January 2009 proved to be a demanding month for acute services within NHSGGC recording a figure of 97% compliance against the A & E target. Similar pressures had been acknowledged by other NHS Board areas and it was anticipated that the national figure for January 2009 would be 96% compliance. In terms of February 2009, the start of the month had seen higher compliance figures for the NHS Board than in either December 2008 or January 2009 and there were encouraging signs that bed pressures may be relaxing slightly. Ms Byrne confirmed that the Emergency Care and Medical Services Directorate would continue to work collaboratively with colleagues in other Directorates and key provider agencies to ensure the NHS Board returned to 98% compliance as soon as possible.

Ms Byrne recorded that the Winter Planning Group would meet in April 2009 to assess the NHS Board's performance in 2008/09 and begin planning for 2009/10. This year would again be a four day holiday period. Messages to share with the National Winter Plan Group would also be agreed.

Councillor MacKay welcomed the report and wondered if there was sufficient awareness of the minor ailments services throughout Greater Glasgow and Clyde. Ms Byrne reported that David Walker (Director, Inverclyde CHP and CHCP Lead for Winter Planning) was reviewing all aspects of the Winter Plan from a primary and community care perspective and she would ensure that this be factored into that review.

Director of Acute Services Strategy Implementation and Planning

NOTED

11. THE DIRECTORATE OF FORENSIC MENTAL HEALTH AND LEARNING DISABILITY

A report of the Director of the Mental Health Partnership [Board Paper No 09/06] asked the NHS Board to note an update on Forensic Mental Health and Learning Disability Services since the opening of Rowanbank Clinic, West of Scotland Medium Secure Services in 2007. The NHS Board was also asked to endorse the proposal to locate the National Forensic Learning Disability Unit at Rowanbank Clinic.

ACTION BY

Mrs Hawkins explained that inpatient services, in conditions of medium security, were provided at Rowanbank Clinic in the north of Glasgow with low security and close supervision learning disability services being provided at Leverndale and Dykebar Hospitals on the south-side of the city. Community and outpatient services were based at Clutha House and the Douglas Inch Centre.

She described the policy background examining the provision of mental health and social work services and accommodation for mentally disordered offenders (and others requiring similar services) in the care of the police, prisons, courts, social work departments, the State Hospital, other Psychiatric services in hospital and in the community. She referred to the Scotland and Regional Analysis of Inpatient Beds – this analysis had been used to guide NHS Boards and regional planning partnerships in the development of local services. She set out expectations of the forensic service configuration that was required within Scotland to provide a full range of forensic inpatient services and the level at which these services should be commissioned.

The proposal was submitted to the Scottish Government in January 2009 and was anticipated to conclude by October 2009. In the meantime, NHSGGC was proceeding to open learning disability medium secure beds within Rowanbank Clinic as originally planned.

Rowanbank Clinic was able to accommodate twelve national learning disability beds through the use of a four bed ward originally designed for learning disability activity, along with the availability of eight beds which would be freed up by reducing the West of Scotland Health Boards' male mental illness capacity. West of Scotland Health Boards, through Regional Planning Group discussions, had confirmed their support for adjusting their male mental illness capacity to accommodate national learning disability services.

Mrs Hawkins also referred to the six bed women's medium secure ward currently operational within Rowanbank Clinic. This ward was originally planned for Greater Glasgow activity, but was currently extending access to other West of Scotland Boards. The Scottish Government was in discussion with Health Boards to confirm the number of beds required for Scotland. NHSGGC had indicated its willingness to provide access to Rowanbank Clinic on either a national or regional basis. A decision on this matter was anticipated in the near future.

Changes to the function of Rowanbank Clinic were made late on in the planning stages which resulted in the unit taking on a West of Scotland function, on an interim basis.

Mrs Hawkins explained that, following public consultation as part of the Clyde Modernising Health Strategy, this would now become a permanent arrangement. The effect on low secure beds had meant that instead of moving to Rowanbank Clinic, these beds would remain at Leverndale.

This decision meant that there was a requirement to invest in low secure services in the following ways:

- It was intended to transfer Bute Ward from Dykebar to Leverndale – forensic planning guidance and the related matrix of security standards strongly recommended that all forensic beds of a particular function should be located within the one estate.

- There was a need to provide dedicated inpatient beds for women who required low secure services, this would be achieved through a redesign of low secure beds.

ACTION BY

- There was a need to provide low secure male mental illness beds for Clyde – current arrangements saw such patients within Intensive Psychiatric Care Units (IPCU) and admission wards; this investment was accounted for in the Clyde Mental Health Financial Plan.

In response to a question from Councillor Yates, Mrs Hawkins confirmed that an extension would be built at Leverndale Hospital to accommodate these changes. She also described the distribution of costs that would occur with Rowanbank Clinic providing a West of Scotland service – it was anticipated that there would be a saving to NHSGGC.

DECIDED:

- That the update on forensic mental health and learning disability services since the opening of Rowanbank Clinic, West of Scotland Medium Secure Services in 2007 be noted.

- That the proposal to locate the National Forensic Learning Disability Unit at Rowanbank Clinic be endorsed. **Director, Mental Health Partnership**

12. FULL BUSINESS CASE – BARRHEAD HEALTH AND SOCIAL CARE CENTRE

A report of the Director, East Renfrewshire Community Health Care Partnership (CHCP) [Board Paper No 09/07] asked the NHS Board to approve the Full Business Case for Barrhead Health and Social Care Centre for submission to the Scottish Government Health Directorates' Capital Invest Group.

Mr Eltringham explained that the current Barrhead Health Centre was opened in 1981 and had received no significant investment since. Space was severely restricted and this had hampered the development of more locally based services. Social Work teams from three surrounding properties also required relocation.

He explained that a site had been identified as suitable for a new build multi-purpose facility for Health and Social Care services. Agreements had been reached between the Scottish Government and NHSGGC that £15m (around 50%) of the funding for this development and that of the Renfrew Health and Social Work Centre would be provided by the Scottish Government, with the remaining funds being provided through NHSGGC's capital programme and a capital contribution from East Renfrewshire Council. This agreement was reached on the understanding that NHSGGC would seek to repay the Scottish Government funding from the proceeds of the future sale of property within the former Clyde area of the NHS Board's responsibilities.

Mr Eltringham noted that the Outline Business Case was approved by the Performance Review Group at its meeting on 20 March 2007. The Full Business Case identified an NHS capital expenditure requirement of £14.7m and an East Renfrewshire Council (ERC) capital expenditure contribution of £2.93m. The resultant combined capital expenditure of £17.1m indicated a slight favourable variance from the figure identified in the Outline Business Case. The expected additional revenue requirement had fallen from £880k to £876k from Outline Business Case to Full Business Case.

In response to a question, Mr Eltringham confirmed that provision for both the revenue and capital implications of the development had been made within NHSGGC's financial plans.

ACTION BY

Ms Dhir asked about the criteria for assessment of the requirement for a new health centre such as this. Ms Renfrew explained the Board's capital planning process and how it operated to identify projects for capital development. She suggested that NHS Board Members may find it helpful to further understand this process and it was agreed that this form a topic for future discussion at a Board seminar session. **Head of Board Administration**

DECIDED:

That the Full Business Case for Barrhead Health and Social Care Centre for submission to the Scottish Government Health Directorate's Capital Investment Group be approved. **Director, East Renfrewshire CHCP**

13. UPDATE ON THE NEW SOUTH GLASGOW HOSPITALS AND LABORATORY DEVELOPMENT ON THE SOUTHERN GENERAL HOSPITAL SITE

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No 09/08] asked Members to receive feedback on the outcome of the Gateway Review 2 process and an update on progress with the new Adult and Children's Hospitals and Laboratory development at the Southern General Hospital site.

Ms Byrne explained that the Gateway Review investigated the assumptions in the Outline Business Case and proposed approach for delivery of the project. The delivery strategy would include details of the sourcing options, proposed procurement route, supporting information and project methodology. The review would also check that plans for implementation were in place. The review was carried out from 27 to 29 January 2009 and the Review Team found that the project had made significant progress since the first Gateway Review in January 2008. The report set out a series of recommendations based on a traffic light system (red, amber or green status). The overall report status was amber and Ms Byrne outlined the key findings and recommendations from the review in terms of:

- Assessment of delivery approach
- Business Case and Stakeholders
- Risk Management
- Review of current phase
- Readiness for next phase – investment decision

Four green and one amber recommendation had been received. The next Gateway Review (Gateway 3 : Investment Decision) to support the approval of the Full Business Case was scheduled for September 2010.

In terms of an update on progress, Ms Byrne outlined that the overall project programme was divided into six stages over a seven year period. The Project Team and Advisers were currently working to complete Stage 1A of the project. Following the successful outcome of the Gateway 2 Review, the procurement stage had commenced. She summarised developments relating to:-

- Clinical Output Specifications – The development of the exemplar design was slightly behind the programme dates but would be accommodated within the overall timetable without impact on the tender issue date by end of 14 April 2009.

- Master Plan – The master plan had further developed and a presentation was made to Glasgow City Council with follow-up discussions arranged to manage the approval of the master plan by June 2009.

ACTION BY

- Laboratories – The revised scope had been confirmed and the work required to develop the designs was currently out to tender.

- Energy Centre and Utilities – A decision to construct the new energy centre along with the laboratories build would be made at the end of February 2009.

- FM/Goods Delivered – The requirements had been agreed and had been incorporated into the design.

- Section 75 Agreement – The work to complete negotiation with Glasgow City Council on the Section 75 Agreement had still to be concluded. The total contribution from NHSGGC in relation to the Southern General Hospital project was £6.25M (inclusive of VAT) which was contained in the project cost plan.

DECIDED:

That the feedback on the outcome of the Gateway Review 2 process and an update on progress with the new Adult and Children's Hospitals and Laboratory development at the Southern General Hospital site be received. **Director of Acute Services Strategy Implementation and Planning**

14. COMMUNITY ENGAGEMENT UPDATE ON NEW HOSPITALS

A report of the Head of Community Engagement and Transport [Board Paper No 09/09] asked Members to receive an update on community engagement activity in relation to key milestones of the Acute Services Review and, in particular, the new hospitals.

Mr McGrogan set out the preparations to engage the public on the next phases of the Hospital Modernisation Programme (Acute Services Review) – the opening of the New Stobhill and Victoria Hospitals and the early design stages of the new South Glasgow Hospitals.

He explained that, since its inception in 2004, the Community Engagement Team had met with tens of thousands of people. It had sought to listen to, involve and engage patients, carers and members of the public in a number of different ways including attendance at meetings, presentations to interested groups, drop-in sessions and outreach work.

Mr McGrogan summarised the Team's activity in respect of the new Stobhill and Victoria Hospitals and the new South Glasgow Hospitals. He highlighted the arrangements made to inform and listen to members of the public regarding these hospitals and explained that the process of engagement would be reviewed to learn lessons and inform the subsequent engagement and communication activities as the Acute Services Review was further implemented. He acknowledged the work that had taken place to ensure the design brief for the new South Glasgow Hospitals captured the high level aspirations of patients, carers and families. Work to secure employment opportunities for local communities in the construction of the new buildings had also taken place and a partnership approach to exploring and exploiting other opportunities presented by the new hospitals' investment had been established.

NOTED

ACTION BY

15. FINAL REPORT REGARDING THE CAMBUSLANG AND RUTHERGLEN/NORTHERN CORRIDOR TRANSFER

A report of the Director, South Lanarkshire CHP, Director, North Lanarkshire CHP and Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs, NHSGG&C [Board Paper No 09/10] set out the final progress report on moving towards full implementation of the approved plans to transfer accountability, planning and governance for the localities of Cambuslang/Rutherglen and the Northern Corridor to NHS Lanarkshire.

Both NHS Boards approved the transfer, in principle, in February 2008, subject to this being undertaken in line with current statutory and regulatory directions and with an appropriate implementation process which ensured safe and legal transfer.

Following this decision, a properly constituted Project Board was established with membership drawn from both Health Boards across a range of disciplines and inclusive of key stakeholders including staff-side representatives and GPs from both localities. The Project Board provided an update on progress with the implementation in October 2008 which identified that matters were on track.
The Project Board was asked to provide a final report to both NHS Boards in February 2009 in order to give an assurance that a legal transfer could be successfully undertaken on 31 March 2009. Mr Lawrie led the NHS Board through progress to date to achieve the safe and sustainable transfer of services. He summarised this in relation to:-

- Human Resources
- Information Management and Technology
- Primary Care (Community) Services
- Primary Care (GMS) Services
- Finance
- Pharmacy and Prescribing

Two areas of work that had not moved as quickly as had been anticipated related to Estates and Facilities Management and also to the roles and responsibilities associated with the Public Health Departments in both Health Boards. Mr Lawrie commented that it had been a well organised project that had been developed with good engagement and involvement of key stakeholders. He summarised the final actions that were to be taken prior to 1 April 2009 and those future actions beyond that date.

In response to a question from Mrs Stewart, Mr Lawrie confirmed that although there were some differences in terms of both NHS Boards' staff policies – they were extremely similar and staff would work to NHS Lanarkshire's.

DECIDED:

- That the positive progress that had been made on this project over the past ten months and the assurance provided in regard to statutory requirements in readiness for the transfer of staff be noted.

- That there would be ongoing work in 2009/10 in regard to the transfer of buildings and associated services be noted.

- That there would be ongoing work in 2009/10 in regard to the transfer of Public Health functions and responsibilities to NHS Lanarkshire at a pace which was both safe and sustainable be noted.

ACTION BY

- That the final decisions in regard to the sign-off of the various Service Level Agreements be delegated to the Chief Executive and appropriate Directors be agreed.

Director, South Lanarkshire CHP, Director, North Lanarkshire CHP and Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs "

- That the final decisions in regard to the final sign-off of the financial transfer be delegated to the Chief Executive and appropriate Directors be agreed.

16. 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 09/11] asked that the NHS Board 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 7 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

17. JOINT WORKING WITH GLASGOW CITY COUNCIL : PROGRESS REPORT

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No 09/12] asked the NHS Board to note progress of the review of joint working with Glasgow City Council.

Ms Renfrew explained that the review was covering a wider range of areas of joint work, including community planning, children's services planning, health improvement and partnership arrangements (in addition to those delivering services). The focus was not just on processes and systems for doing joint business but also on organisational arrangements and the cultures and behaviours which characterised ways of working together. The review had four elements and Ms Renfrew outlined progress on each as follows:

- Documentation of all joint arrangements with the City – this was underway.

- Systematic analysis of the models of joint working from other parts of the UK between major NHS systems and Local Authorities – this was underway.

- A structured questionnaire to gain a wide range of intelligence on the realities of joint working – this had been concluded and completed by around 80 staff.

- Workshops to enable all those involved in joint working to put forward their views and issues – the schedule of six workshops had been completed and were attended by over 100 staff from across the organisation.

ACTION BY

The aim was to conclude the work by the end of April 2009 and create an informal opportunity to discuss the outcome with NHS Board Members at the May 2009 NHS Board seminar before finalising a report and recommendations. **Head of Board Administration**

NOTED

18. GLASGOW CITY CHCPS : REPORT ON JOINT DEVELOPMENT WORK

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No 09/13] asked the NHS Board to note progress in the joint development work with Glasgow City Council and arrangements for the outcome of that work to be reported to an additional NHS Board meeting on Tuesday 3 March 2009 at 10.30 am.

Ms Renfrew provided Board Members with a report on progress and advised of the formal process to conclude this programme of work.

Progress had been made with the City Council in a number of areas which were of concern to them. A number of issues raised by the NHS, however, remained unresolved, particularly in relation to the financial arrangements and delegation of decision making which were fundamental to the agreed Scheme of Establishment for the CHCPs.

The Council Leader met the NHS Board Chair on 13 February and again restated his commitment to ensuring that the full range of issues was addressed. The NHS Board Chief Executive was continuing to work with the Council to resolve the outstanding points of concern.

Ms Renfrew proposed that on 3 March 2009 the NHS Board would be able to confirm that all matters had been positively concluded or view proposals to enable it to consider whether the CHCP Scheme of Establishment should be revised if acceptable conclusions had not been reached.

DECIDED:

That progress in the joint development work with Glasgow City Council and arrangements for the outcome of that work be reported to an additional NHS Board meeting on Tuesday 3 March 2009 at 10.30 am be noted. **Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs**

19. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer – Acute Services Division [Board Paper No 09/14] asked the NHS Board to note progress against the national targets as at the end of December 2008.

Mr Divers led the NHS Board through the report noting the NHS Board's performance. He highlighted the following:

- Outpatient Waiting Times – at the end of September 2008, the NHS Board achieved the 15 week outpatient target - six months early. The next milestone towards achieving 18 weeks referral to treatment would see no patient wait more than 12 weeks from GP referral to an outpatient appointment by the end of March 2009. The Acute Division was now working towards delivery of the 12 week waiting time target for outpatients.

At the end of December 2008, no patients were waiting over 14 weeks for an outpatient appointment.

- Inpatient/Day Case Waiting Times – at the end of September 2008, the NHS Board achieved the 15 week inpatient/day case target - six months early. The next milestone towards achieving 18 weeks referral to treatment would see no inpatient/day case wait more than 12 weeks from a decision to undertake treatment to the start of that treatment by the end of March 2009. The Acute Division had largely achieved the 12 week target three months early.

- Diagnostic Waiting Times – as a milestone towards achieving 18 weeks referral to treatment, the maximum wait from referral to MRI scan, CT scan, non-obstetric ultrasound, barium studies, gastroscopy, sigmoidoscopy, colonoscopy and cystoscopy would be 6 weeks by the end of March 2009. This 6 week target was achieved at the end of December 2008 for four of these modalities.

- Cataract Targets – the maximum time from referral to completion of treatment for cataract surgery would be 18 weeks. This target was achieved in December 2007 and had been maintained since that date.

- Hip Fracture – 98% of all hip fracture patients would be operated on within 24 hours of admission to an orthopaedic unit, subject to medical fitness and during safe operating hours. The standard had been met: one patient was operated on out with the 24 hour period following admission and a detailed analysis of the circumstances surrounding this patient had been undertaken.

- Accident and Emergency Four Hour Wait – 98% of Accident and Emergency patients should be treated and discharged, admitted or transferred within four hours of arrival at the department. The NHS Board achieved this target in December 2007 and in the following eleven months. In December 2008, this dropped to 97% compliance due to levels of demand which took the form of very sharp rises in activity at different sites on different days. This position continued into January 2009 when again the NHS Board posted 97% compliance. A similar pattern had been reported across many NHS Boards in Scotland. The Emergency Care and Medical Services Directorate continued to work collaboratively with colleagues in other Directorates and with key provider agencies to ensure the NHS Board returned to 98% compliance as soon as possible.

- Cancer Waiting Times – 95% of all urgent referrals with suspected cancer should wait a maximum of 62 days from urgent referral to treatment (31 days for breast cancer). All patients referred as urgent were tracked to ensure monitoring of the progress along the patient journey. The monthly MMI returns would indicate that the NHS Board achieved the 95% target in November and December 2008.

- Chest Pain – the maximum wait from GP referral through a rapid access chest pain clinic or equivalent to cardiac intervention was 16 weeks. The NHS Board was now only responsible for rapid access chest pain services, with a target waiting time of two weeks as part of the overall 16 week patient journey. The NHS Board met the two week target throughout 2008.

- Delayed Discharge – The NHS Board was now required to maintain a performance standard of no patients waiting over six weeks for discharge. In two authorities, some areas this had not proved possible but joint work had continued where there were patients whose cases had not progressed quickly enough and where access to funding remained an issue.

ACTION BY

- Stroke – The national QIS stroke targets were that 80% of fast track referrals to Stroke/Transient Ischaemic Attacks (TIA) clinics should be seen within 14 days and 80% of stroke patients should have a CT or MRI scan within 48 hours of admission. The Glasgow Managed Clinical Network had reviewed and changed the CT target from 48 to 24 hours as more clinically pertinent to stroke management. Fast track referrals in Glasgow met the 80% target. Progress in Clyde had shown improvement. Additional clinics had been undertaken at Inverclyde Royal and it was expected that the target would be achieved and maintained from January 2009 onwards.

Mr Carson referred to an action within the Matters Arising Rolling Action List where it had been agreed that delayed discharges would be tracked and consideration given to whether independent living allowances and packages would assist. Mr Divers agreed that this would be included in future reports. **Chief Operating Officer**

NOTED

20. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2008

A report of the Director of Finance [Board Paper No 09/15] asked the NHS Board to note the financial position for the first eight months of the financial year.

Mr Griffin reported that the NHS Board and its Operational Divisions were currently reporting an outturn in line with the revenue budget for the first eight months of the year. The NHS Board continued to forecast a revenue breakeven position for the 2008/09 year end.

Expenditure on Acute Services was running close to budget with expenditure running £0.6m under budget for the first eight months of the year. The most significant individual cost pressure continued to be expenditure on energy costs due to price increases which would result in an additional in-year cost pressure of £6m to £7m for 2008/09. The Acute Division had indicated that the in-year cost could be absorbed non-recurrently using funds released from saving schemes and in-year underspends.

Expenditure on NHS Partnerships was running slightly ahead of budget for the year to date. In particular, expenditure within the Renfrewshire CHP remained above budget. This was mainly due to additional expenditure on General Medical Services within the Clyde area which continued to run at an annual level of £1.8m above available funding.

Total expenditure for the Clyde area was running in line with budget for the year to date.

NOTED

21. NHS GG&C SCOTTISH PATIENT SAFETY PROGRAMME (SPSP) UPDATE FOR NHSGGC BOARD FEBRUARY 2009

A report of the Board Medical Director and Head of Clinical Governance [Board Paper No 09/16] asked Members to review and comment on the progress achieved by the NHS Board in implementing the Scottish Patient Safety Programme (SPSP).

ACTION BY

Dr Cowan led the NHS Board through the report emphasising that safeguarding patients receiving care was a strategic priority for the NHS Board. As such, the Acute Service Division was currently supporting 31 pilot sites and he provided an overview of progress to date with the programme.

The SPSP approach focused on improving safety by increasing the reliability of healthcare processes in acute care. This was achieved by front line teams testing and establishing more consistent application of evidence based clinical or communication processes through four clinical work-stream packages. These packages were for Critical Care, General Ward, Peri-Operative and Medicines Management. The success of this activity was monitored through a measurement framework and supported by enhanced commitment to the priority of patient safety from organisational leadership. The programme was planned and tracked around six component objectives.

Dr Cowan explained that after the first challenging year supporting SPSP implementation, the NHS Board had made progress that had been positively evaluated at a national and local level. The Acute Service Division had further major challenges in completing the first two phases and launching the spread in the next year.

The scale of spread was unique to NHSGGC but the approach and commitment of staff was encouraging and he remained hopeful that the same level of progress would be sustained.

NOTED

22. AUDIT COMMITTEE MINUTES : 11 NOVEMBER 2008 AND 27 JANUARY 2009

The Minutes of the Audit Committee meetings held on 11 November 2008 [A(M)08/06] and 27 January 2009 [A(M) 09/01 were noted.

NOTED

23. INVOLVING PEOPLE COMMITTEE MINUTES : 1 DECEMBER 2008

The Minutes of the Involving People Committee meeting held on 1 December 2008 [IPC(M)08/06] were noted.

NOTED

24. PHARMACY PRACTICES COMMITTEE MINUTES : 1 DECEMBER 2008

The Minutes of the Pharmacy Practices Committee meeting held on 1 December 2008 [PPC(M)08/24] were noted.

NOTED

25. GREATER GLASGOW AND CLYDE CLINICAL GOVERNANCE COMMITTEE MINUTES : 2 DECEMBER 2008

The Minutes of the Greater Glasgow and Clyde Clinical Governance Committee meeting held on 2 December 2008 [CGC(M)08/6] were noted.

NOTED

ACTION BY

26. PERFORMANCE REVIEW GROUP MINUTES : 20 JANUARY 2009

The Minutes of the Performance Review Group meeting held on 20 January 2009 [PRG(M)09/01] were noted.

NOTED

27. AREA CLINICAL FORUM MINUTES : 5 FEBRUARY 2009

The Minutes of the Area Clinical Forum meeting held on 5 February 2009 [ACF(M)09/1] were noted.

NOTED

The meeting ended at 12.50pm