

NHSGG&C(M)10/01  
Minutes: 1 - 19

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, 16 February 2010 at 9.30 am**

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**P R E S E N T**

Mr A O Robertson OBE (in the Chair)

Dr C Benton MBE	Dr M Kapasi MBE
Mr R Calderwood	Mr I Lee
Mr R Cleland	Councillor D MacKay
Councillor J Coleman	Mrs J Murray
Dr B Cowan	Councillor J McIlwee
Ms R Crocket	Mrs R K Nijjar
Mr P Daniels OBE	Councillor I Robertson
Dr L de Caestecker	Mr D Sime
Ms R Dhir MBE	Mrs E Smith
Mr D Griffin	Councillor A Stewart
Mr P Hamilton	Mr K Winter
Councillor J Handibode	Councillor D Yates

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

Ms H Byrne	..	Director of Acute Services Strategy, Implementation and Planning
Dr Emilia Crighton	..	Consultant in Public Health Medicine (for Minute No. 10)
Ms S Gordon	..	Secretariat and Complaints Manager
Mrs J Grant	..	Chief Operating Officer, Acute Services Division
Mr J C Hamilton	..	Head of Board Administration
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, Professor D Barlow, Mr C Bell, Mr G Carson, Mr G McLaughlin and Mr B Williamson.

**2. CHAIR'S REPORT**

- (i) On 11 January 2010, Mr Robertson and Mr Calderwood had hosted a meeting with Norwegian Health Ministers and Senior Administrators. Many similarities in service provision were raised especially around services provided in the community. The visitors had been very appreciative of the presentations delivered particularly in respect of the NHS Board's structures and handling of Public Health matters.
- (ii) Throughout December 2009 and January 2010, Mr Robertson and Professor Carol Tannahill had met with representatives from the University of Glasgow, Scottish Government and Glasgow City Council as key stakeholders of the Glasgow Centre for Population Health. This was ahead of next year's review of the Centre and its funding by these key stakeholders. The discussions had been positive with all partners giving continued support to the Centre.
- (iii) Mr Robertson had visited Renfrewshire, West Glasgow and East Renfrewshire CH(C)Ps. He had also been accompanied by Mrs E Smith to visit the Community Partnership arrangements in Edinburgh to see their progress in terms of service provision.
- (iv) Mr Robertson had visited two hospices, the Marie Curie Hospice on 18 January and the Prince and Princess of Wales Hospice on 22 January 2010. In both of these hospices there was an increasing emphasis on the provision of palliative care at home. Marie Curie Hospice had been in the process of moving into their new accommodation with a reduction of beds from 35 to 30.
- (v) Mr Robertson had met with the Chair of St Margaret's Hospice on 18 December 2009, as a follow up to their previous meeting of 4 December 2009. The meeting had been constructive and focused on two key issues, namely, the provision of further financial information and the awaited outcome of the Palliative Care Managed Clinical Network (MCN) deliberations. Mr Robertson welcomed these informal meetings. Once these further two items of information were available, the two Chairs would meet again. In the meantime, Professor Martin advised that the Hospice would not be responding to Mr Calderwood's letter of 26 November 2009, setting out the preferred options for future use of the 30 continuing care beds. However, in the week following this meeting, a letter had been received from the Hospice's Chief Executive rejecting consideration of the NHS Board's options. This had been a disappointing development.
- (vi) On 10 February 2010, Mr Robertson had welcomed the First Minister and Cabinet Secretary for Health and Wellbeing who jointly opened the new Victoria Ambulatory Care Hospital. Also on 10 February 2010, Mr Robertson had attended a reception in Edinburgh for the Women's Royal Volunteer Service (WRVS). He had met with their Chief Executive who had welcomed the developing good relationship NHS Greater Glasgow and Clyde had with the WRVS particularly in taking forward joint work on a site by site basis.

NOTED

**3. CHIEF EXECUTIVE'S UPDATE**

- (i) Mr Calderwood referred to the media and political interest in the NHS Board's plans for Blawarthill and the separate issue of the position with the continuing care contract with St Margaret's Hospice. The NHS Board had responded to media enquiries using the detailed information which had been considered by the NHS Board. Similarly, a detailed report had been provided to the Scottish Government Health Directorates, again, entirely based on the consideration of the matter by the NHS Board and its Performance Review Group.

The Chairman invited members to express any outstanding concerns or issues relating to either his own or the Chief Executive's reports regarding St Margaret's Hospice and Blawarthill Hospital. In the absence of concerns being voiced, the agenda moved to the next item.

NOTED

**4. MINUTES**

- (i) On the motion of Councillor D Yates, seconded by Mrs E Smith, the Minutes of the NHS Board meeting held on Tuesday 1 December 2009 [NHSGG&C(M)09/7] were approved as an accurate record and signed by the Chair.
- (ii) On the motion of Councillor D Yates, seconded by Mr K Winter, the Minutes of the NHS Board meeting held on Tuesday 15 December 2009 [NHSGG&C(M)09/8] 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. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE**

A report of the Board's Medical Director and Head of Clinical Governance [Board Paper No. 10/01] asked the NHS Board to review and comment on the progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Cowan reminded members that the programme focused on improving safety by increasing the reliability of health care processes within Acute care. This was achieved by frontline teams testing and establishing more consistent application of clinical and/or communication processes. Success was monitored through a measurement framework and supported by a visible commitment to safety by the organisation and the achievement of an overarching set of improvement aims which currently were as follows:-

- Mortality – 15% reduction
- Adverse events – 30% reduction
- Ventilator associated pneumonia - reduction
- Central line bloodstream infection - reduction
- Blood sugars within range (ITU/HDU) – 80% or > within range
- MRSA bloodstream infection – 50% reduction
- Crash calls – 30% reduction
- Harm from anti-coagulation – 50% reduction in ADEs
- Surgical site infections – 50% reduction (clean).

Dr Cowan commented on the NHS Board's progress in relation to each of the above nine aims. He also summarised the key actions scheduled for completion in early 2010 and confirmed that all were progressing well.

In response to a question from Dr Kapasi, Dr Cowan reported that the spread target for 2010 was for 90 new ward teams to formally commence the programme. The process of working with each Directorate to agree the next wards for inclusion and how best to undertake their preparation for launch, was now underway. Initial indications confirmed that this target should be achieved, however, the main concern was in maintaining an adequate support structure. An initial proposal to redirect existing clinical governance resources was being worked through with Directorates with the expectation that this was in place to initiate education and awareness for new teams in April 2010. In terms of an overall expansion plan, it was anticipated that by the end of 2011, all wards would have completed the programme. It was paramount that the wards would become self supporting as, currently, wards were requiring more support from local Clinical Governance Teams than was originally anticipated. In rolling out the programme, Dr Cowan expected that necessary support from Clinical Governance Teams would become less as the principles of SPSP were undertaken more routinely.

Mr Robertson suggested that NHS Board members may benefit from a seminar session exploring, in more detail, the implications of the SPSP. This was welcomed and it was agreed that Dr Cowan provide such an update at a future NHS Board seminar.

**Head of Board  
Administration**

NOTED

**7. HEALTHCARE ASSOCIATED INFECTION – MONITORING REPORT**

A report of the Medical Director [Board Paper No. 10/02] asked the NHS Board to note the latest of the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde. The report presented data on the performance of NHS Greater Glasgow and Clyde on a range of key indicators at national and individual hospital level.

Dr Cowan reminded members that the bi-monthly report 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.

In summarising the report for members, Dr Cowan reported the following:-

- If current trends were maintained, NHS Greater Glasgow and Clyde would achieve the target of a 35% reduction in S.aureus bacteraemias by 2010. In the quarter July – September 2009, NHS Greater Glasgow and Clyde was below the projected April 2010 target of 152 cases per quarter.
- The national report published in January 2010 (July – September 2009) indicated that the annual rate of C.difficile infection in NHS Greater Glasgow and Clyde in the over 65s was 0.43 per 1000 acute occupied bed days. This placed NHSGGC well below the 2011 target of 0.9 per 1000 acute occupied bed days and was the second quarter in a row that the NHS Greater Glasgow and Clyde rate was 0.43.
- The Surgical Site Infections (SSI) rates in NHS Greater Glasgow and Clyde remained below the national average for all procedures apart from hip arthroplasty.
- NHS Greater Glasgow and Clyde had demonstrated a steady rise in hand hygiene compliance during the national audit periods from a 62% baseline in February 2007 to achieve the 90% target in September 2008 and a current figure of 92%.
- All areas within NHSGGC scored green (>90%) in the most recent report on the national cleaning specification.

Dr Cowan confirmed that as at December 2009 there were no ward based exception reports.

In response to a question from Dr Kapasi concerning surgical site infection rates, Dr Cowan confirmed that the monitoring included post-hospital monitoring once the patient was discharged.

Mr Lee asked about hand hygiene compliance and, in particular, with medical staff. Dr Cowan confirmed that, as at the end of December 2009, compliance with this group of NHS Greater Glasgow and Clyde staff had fallen to 75%. In terms of follow up, he explained that this was conducted with individuals identified via local audits as not complying with hand hygiene guidance.

In response to a question concerning the Statistical Process Charts (SPCs), Dr Cowan confirmed that their most common use was in infection control practice in relation to MRSA and C.difficile infections. Calculations were based upon the ward's historical infection rate to produce three lines, the upper and lower control limits and the centre line. The setting of the upper control limit allowed local teams to "trigger" actions promptly in response to any increase in the number of patients identified. As such, SPCs were at their most effective when used to reflect what was going on in individual wards/departments, however, the data would be used to develop trajectories for the Directorates within NHS Greater Glasgow and Clyde in relation to C.difficile and MRSA.

NOTED

## **8. VALE OF LEVEN VISION: UPDATE ON IMPLEMENTATION**

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No. 10/03] asked the NHS Board to receive an update on progress with implementation of the vision for the Vale of Leven Hospital.

Ms Byrne explained that, following a period of formal consultation from November 2008 to January 2009, and the NHS Board's decision in February 2009, the Chairman submitted a recommendation on the vision for the Vale of Leven Hospital to the Cabinet Secretary in March 2009. In July 2009, the Cabinet Secretary set out her acceptance of the vision and:-

- Approved the NHS Board's main proposals.
- Reserved final decision on the future of the Christie Ward pending a further report from the NHS Board confirming level of admission in 12-18 months time.
- Set out the requirement for NHS Greater Glasgow and Clyde to carry out promotion of current and future services provided from the Vale of Leven.
- Requested the appointment of a Monitoring Group to oversee development and delivery of the service change plans.

Ms Byrne summarised the structures set up to oversee progress which included the establishment of a number of groups. She led the NHS Board through progress on the main components of the vision including:-

- Unscheduled care/rehabilitation models
- Planned care model
- Mental Health update
- Mental Health Services for older people
- Alexandria Health Centre
- Scottish Ambulance Service
- Capital Projects.

Over and above these, work was underway to progress development of a communication and publicity plan which would incorporate the publication of leaflets, creation of a website and local advertising.

NOTED

## **9. PROPOSAL FOR HOMELESSNESS PARTNERSHIP**

A report of the Director of Corporate Planning and Policy/Lead NHS Director Glasgow City CHCPs [Board Paper No. 10/04] asked the NHS Board to agree to the dissolution of the Homelessness Partnership on the basis of the migration of its responsibilities into Community Health and Care Partnerships.

Ms Renfrew explained that the Homelessness Partnership was a formal Partnership between the NHS and Glasgow City Council and had direct responsibility for the delivery of NHS services and NHS staff. It was established to drive forward the closure of the large hostels and the development of specialist Health and Social Care Services to these highly vulnerable residents. Glasgow City Council indicated in August 2009 that it wished to carry out a review of the structure of the Homelessness Partnership. The NHS agreed to participate in the review on the basis that its outcome would be reported back to the Joint Partnership Board (JPB).

Since then, Ms Renfrew explained that a report, prepared for the Council's Executive Committee, was submitted to the November 2009 meeting of the Joint Partnership Board, recommending the dissolution of the Partnership and the migration of a number of its functions into Social Work Centre. This paper, however, was silent on the future arrangements for the NHS Services that the Partnership managed. Given this, the Joint Partnership Board considered a further paper which set out the perspective of the NHS on the Council's conclusions and agreed that there needed to be further consultation with the NHS on these issues.

Thereafter, at its December 2009 meeting, the Joint Partnership Board accepted a report from the NHS Lead Director and CHCP Directors which proposed that the responsibilities of the Partnership migrate to CHCPs with a host CHCP arrangement for specialist services. On that basis, the Joint Partnership Board agreed to support the dissolution of the Partnership subject to approval by the NHS Board. Ms Renfrew reported that since that time, CHCP Directors had developed detailed proposals to implement these changes which were agreed at the January 2010 meeting of the Joint Executive Group, subject to identifying which CHCP would act as the host. Ms Renfrew summarised the agreed proposals and recorded that these would be reported to a further meeting of the Joint Partnership Board for approval.

She also highlighted the clear benefits to dissolving the Homelessness Partnership but cautioned that these benefits only applied if, as in the proposals agreed by the Joint Partnership Board and the Joint Executive Group, the responsibilities of the Partnership were migrated to the CHCPs. This ensured continued service integration, synergies with support services provided within CHCPs, alignment of service delivery and planning leadership and offered the additional benefit of better alignment to the delivery and commissioning of other services for vulnerable people which would be the responsibility of CHCPs.

As Vice Chair of the Joint Partnership Board, Mrs Smith commended all that the Homelessness Partnership had achieved to date and was confident that the proposals ensured continued service integration and would build on the platform well established by the Partnership.

As Vice Chair of a Glasgow City CHCP, Mrs Murray welcomed the proposals and was comfortable that they sat well within the responsibilities of the CHCPs.

#### DECIDED

That the dissolution of the Homelessness Partnership, on the basis of the migration of its responsibilities into Community Health and Care Partnerships, be agreed. In addition, the Board acknowledged the very significant achievements of the Homelessness Partnership.

**Director of  
Corporate  
Planning and  
Policy/Lead NHS  
Director Glasgow  
City CHCPs**

#### **10. PUBLIC HEALTH SCREENING PROGRAMMES ANNUAL REPORT: 1 APRIL 2008 TO 31 MARCH 2009**

A report of the Director of Public Health [Board Paper No. 10/05] asked the NHS Board to note the "Public Health Screening Programmes Annual Report: 1 April 2008 to 31 March 2009".

Mr Robertson introduced Dr Crighton, Consultant in Public Health Medicine, to present this report. Dr Crighton reported that screening was a public health service offered to specific population groups to detect potential health conditions before symptoms appeared. Screening had the potential to save lives and improve quality of life through early diagnosis of service conditions. The Annual Report presented information about the following screening programmes offered to residents across NHS Greater Glasgow and Clyde for the period 2008/09:-

- Cervical Screening
- Bowel Screening
- Breast Screening
- Communicable Diseases in pregnancy
- Down's Syndrome and other Congenital Anomalies
- Newborn Bloodspot
- Universal Newborn Hearing
- Diabetic Retinopathy Screening
- Pre-School Vision Screening

Dr Crighton reported that, in addition, the report also highlighted plans for:-

- The replacement of the existing Pregnancy Screening Programme offered for Down's Syndrome and other congenital anomalies.
- The implementation of Haemoglobinopathy Screening both during pregnancy and for newborn babies.
- The extension of the Newborn Bloodspot Screening Programme to include screening for Medium Chain Acyl CoA Dehydrogenase Deficiency (MCADD).

Dr Crighton confirmed that, each year, approximately 250,000 NHS Greater Glasgow and Clyde residents were eligible for screening. As part of the NHS Board's commitment to tackling inequalities and health, the Public Health Screening Unit engaged with voluntary and statutory services to identify effective ways to encourage and promote uptake of screening programmes.

Dr Crighton led the NHS Board through a summary of each of the above named screening programmes confirming that they stretched across the whole organisation and their successful delivery relied on a large number of individuals working in a co-ordinated manner towards common goals in a quality assured environment. As such, it was essential that good information management systems were in place to monitor and evaluate each component and the overall performance of every screening programme offered.

Dr de Caestecker commended the efficiency of the screening programmes and reiterated that they could prevent disease. She briefly described the accountability arrangements for the screening programmes across NHS Greater Glasgow and Clyde in terms of quality, governance and risk management.

Mrs Nijjar asked if the information on uptake of the screening programmes could be split into CH(C)Ps area. Dr Crighton confirmed that it could and was regularly reported to CH(C)P Directors. In terms of differences in uptake across the NHS Board's area, it was clear that uptake was lower in areas of high deprivation.



In response to questions from Dr Kapasi, Dr Crighton confirmed that Public Health staff worked with GP practices and CH(C)Ps to encourage and support them in increasing the uptake rates for Cervical Screening although the increase in the uptake rate for 2008/09 was due to the intense publicity caused by Jade Goody's illness and death from Cervical Cancer. She confirmed that Chlamydia Screening was not yet scheduled to be undertaken in NHS Greater Glasgow and Clyde. In relation to Diabetic Retinopathy Screening, as at May 2009, 71.4% of people with diabetes had been screened for Diabetic Retinopathy. Capacity had been expanded to encourage a greater uptake and staff were engaging with patients who "did not attend". Work was ongoing to help improve the current uptake rate.

In response to a question from Mr P Hamilton concerning the Bowel Screening programme, Dr Crighton confirmed that since its implementation in April 2009, NHS Greater Glasgow and Clyde had detected a higher percentage of positive results than the Scottish average. In response to a follow up question from Mr Daniels, Dr Crighton confirmed that the 244,000 NHS Greater Glasgow and Clyde residents invited to participate in the Bowel Screening Programme were all those eligible between 1 April 2009 and 31 March 2010.

#### NOTED

### **11. WAITING TIMES AND ACCESS TARGETS**

A report of the Chief Operating Officer (Acute Services Division) [Board Paper No. 10/06] asked the NHS Board to note progress against the national targets as at the end of December 2009.

Mrs Grant led the NHS Board through the report and highlighted the actions being taken to deliver the waiting times and access targets.

In relation to cancer waiting times, Mr Calderwood reported that Quarter 3 (October – December 2009) validated ISD performance had also met the target of a minimum of 95% of all urgent referrals with suspected cancer achieving a maximum wait of 62 days from urgent referral to first treatment (31 days for breast cancer). Confirmation of this had been issued by ISD that morning. Mrs Grant also described the significant pressure in orthopaedics in maintaining their 12 week outpatient target and the move to 9 weeks for inpatient/day surgery over the winter months. The elective programme, in particular, had proved very challenging, firstly, because of significant increases in trauma admissions and, secondly, with referral trends demonstrating a significant increase in new outpatients. This increase in demand was beyond that which had been projected and was, in turn, distorting inpatient and day case activity requirements. Mrs Grant explained that to address this, the Acute Division had deployed a number of initiatives which included increased non recurring internal sessions resulting in a 9% activity increase on last year's outturn position, as well as external capacity being utilised at the Golden Jubilee Hospital and the private sector.

Councillor MacKay referred to the delayed discharge figures and the requirement that the NHS Board had to maintain a performance standard of no patient waiting over 6 weeks for discharge. At the moment, there were 13 patients delayed awaiting local authority funding, 11 in Renfrewshire and 2 in Inverclyde.

He confirmed that additional funding had been identified in Renfrewshire to support further care home placements and that good joint working continued between the local authority and NHS staff to see continued improvements in this regard.

NOTED

## **12. WINTER PLAN – 2009/2010: PROGRESS REPORT**

A report of the Director of Acute Services Strategy, Implementation and Planning [Board Paper No. 10/07] asked the NHS Board to receive an update on Winter Planning 2009/10 including a progress report on how the plan worked over the festive period and into the new year.

Ms Byrne reminded the NHS Board that the 2009/10 Winter Plan for NHS Greater Glasgow and Clyde had been developed on a single system basis and included partners who were involved in the delivery of services. Overall, the Winter Plan worked effectively particularly given that December 2009 and January 2010 had proved to be extremely busy and challenging months with severe weather conditions impacting considerably on services. She briefly summarised how the plan had functioned with key partners including Primary Care, NHS 24, the Out-of-Hours GP Service, the Scottish Ambulance Service, Acute Services, Mental Health/Addiction Services and Community Pharmacy. Daily reporting had been provided to key partners across the system by the Health Information and Technology Directorate. These reports supported both Winter and Flu Planning and the provision of this information had been beneficial with further work being undertaken to consider how better use could be made of information to predicatively plan services.

In line with the Scottish Government's requirements, a weekly winter pressure report was sent to the Health Directorate providing information regarding the number of A&E attendees, ward closures and outbreaks. The NHS Board's Communications Department was in contact with the Scottish Government as necessary to inform them of any exceptional circumstances.

In conclusion, Ms Byrne reported that, given the extreme pressures on Acute Services and partner services, NHS Greater Glasgow and Clyde performed well over the festive period. Working together, across the system, in the pre-winter period proved beneficial in ensuring good communication between partners. Similar pressures had been acknowledged by other Board areas.

Councillor Robertson welcomed this report and noted that lessons learned would be incorporated into the 2010/11 Winter Plan where there would again be a four day holiday period. He also recognised the contribution made by local authorities during this holiday period.

Mr Robertson recorded that this would be the final report from Ms Byrne before she took up post as Director of Strategic Commissioning and Deputy Chief Executive for the Primary Care Trust in Croydon. Ms Byrne had made a significant contribution to the success of NHS Greater Glasgow and Clyde over the last four years and, on behalf of the NHS Board, he offered her his best wishes. In return, Ms Byrne thanked Mr Robertson, Mr Calderwood and the other NHS Board members and her colleagues for their good wishes. She had enjoyed her role in leading the NHS Board towards its goal of a new Southside adult and children's hospital.

NOTED

**13. FINANCIAL MONITORING REPORT FOR THE 8 MONTH PERIOD TO 30 NOVEMBER 2009**

A report of the Director of Finance [Board Paper No. 10/08] asked the NHS Board to note the financial performance for the first 8 months of the financial year.

Mr Griffin reported that the NHS Board was currently reporting an expenditure outturn of £1.6M in excess of its budget for the first 8 months of the year. At this stage, however, he considered that a year-end breakeven position remained achievable. There remained a number of factors, however, which could have a significant negative impact on the NHS Board's financial position during 2009/10, such as, the costs of pandemic flu, the outcome of Agenda for Change appeals and prescribing expenditure trends.

Mr Griffin led the NHS Board through the detail of the Board's income and expenditure report and capital expenditure summary. It was clear from these and the mid year review of the NHS Board's Financial Plan that these demonstrated a level of pressure which was consistent throughout NHS Scotland. Mrs Smith recognised these challenges and considered that the report gave a clear exposition of the situation in which public sector organisations were within the current financial climate. It was apparent from the figures and comments contained within the report that financial pressures were challenging but she commended Mr Griffin for the clarity of the data provided.

Mr Griffin reminded members that the NHS Board's seminar session scheduled for 2 March 2010 would give a more in-depth analysis of the current financial position and an update on the 2010/11 financial planning process.

NOTED

**14. 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. 10/09] 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 two 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**

**15. AUDIT COMMITTEE MINUTES: 9 NOVEMBER 2009**

The Minutes of the Audit Committee meeting held on 9 November 2009 [A(M)09/5] were noted.

NOTED

**16 CLINICAL GOVERNANCE COMMITTEE MINUTES: 1 DECEMBER 2009**

The Minutes of the Clinical Governance Committee meeting held on 1 December 2009 [CGC(M)09/6] were noted.

Mr Cleland referred to the NHS Board's Organ Donation Committee which reported to the Clinical Governance Committee and recorded his support for the current National Organ Donation campaign.

NOTED

**17. AREA CLINICAL FORUM MINUTES: 3 DECEMBER 2009**

The Minutes of the Area Clinical Forum meeting held on 3 December 2009 [ACF(M)09/5] were noted.

NOTED

**18. PHARMACY PRACTICES COMMITTEE MINUTES: 16 DECEMBER 2009**

The Minutes of the Pharmacy Practices Committee meeting held on 16 December 2009 [PPC(M)09/09] were noted.

NOTED

**19. ANY OTHER BUSINESS**

Mr Robertson acknowledged the contribution to the NHS made by John Bannon MBE over the past 21 years and whose term of office as a non Executive member was due to expire on 31 March 2010. On behalf of the NHS Board, Mr Robertson wished John well in his future endeavours.

NOTED

The meeting ended at 11:15 am