

NHSGG&C(M)12/04

Minutes: 61 – 77

NHS GREATER GLASGOW AND CLYDE

**Minutes of a Meeting of the
NHS Greater Glasgow and Clyde Board
held in the Board Room, Corporate Headquarters, J B Russell House,
Gartnavel Royal Hospital, 1055 Great Western Road, Glasgow, G12 0XH
on Tuesday, 21 August 2012 at 9:30 a.m.**

PRESENT

Mr A O Robertson OBE (Chair)

| | |
|------------------------|------------------------|
| Dr J Armstrong | Councillor A Lafferty |
| Dr C Benton MBE | Mr I Lee |
| Ms M Brown | Councillor M Macmillan |
| Mr R Calderwood | Ms R Micklem |
| Mr G Carson | Councillor J McIlwee |
| Ms R Crocket | Councillor M O'Donnell |
| Mr P Daniels OBE | Dr R Reid |
| Dr L de Caestecker | Councillor M Rooney |
| Prof A Dominiczak | Rev Dr N Shanks |
| Mr R Finnie | Mr D Sime |
| Councillor J Handibode | Mrs P Spencer |
| Mr P James | Mr B Williamson |
| Dr M Kapasi MBE | Mr K Winter |

IN ATTENDANCE

| | |
|-----------------|--|
| Ms S Gordon | Secretariat Manager |
| Mrs J Grant | Chief Operating Officer, Acute Services Division |
| Mr J C Hamilton | Head of Board Administration |
| Mrs A Hawkins | Director, Glasgow City CHP |
| Mr A McLaws | Director of Corporate Communications |
| Dr A Scoular | Consultant in Public Health Medicine (for Minute No. 70) |
| Ms G Woolman | Audit Scotland (to Minute No. 71) |

ACTION BY

61. APOLOGIES AND WELCOME

Apologies for absence were intimated on behalf of Mr I Fraser and Councillor M Kerr.

Mr Robertson welcomed Mr R Finnie, Councillor A Lafferty, Councillor M Macmillan and Councillor M O'Donnell to their first NHS Board meeting as newly appointed members of the NHS Board. He also welcomed back Councillor J Handibode as a reappointed member.

NOTED

62. DECLARATION(S) OF INTEREST(S)

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

NOTED

63. CHAIR'S REPORT

- (i) Mr Robertson had attended three meetings to take forward the reform of community planning arrangements including attending, on 25 June 2012, the Glasgow City Council Community Planning Partnership Strategic Board meeting. Mr Robertson was one of two NHS Board Chairs invited to join the national Group which represented all the different interests involved in community planning in the 32 local authority areas in Scotland.
- (ii) On 13 July 2012, Mr Robertson met with the Head of the Women's Royal Voluntary Service (WRVS) in Scotland and their Service Delivery Manager to discuss how the WRVS could extend its engagement across the NHS Board's Acute hospital sites and range of services. The Board's Director of Facilities would take this work forward and identify what further contribution could be made by the WRVS particularly in relation to the new South Side Hospitals.
- (iii) On 16 July 2012, Mr Robertson and Dr L de Caestecker visited Raploch, Stirling to see "Sistema Scotland" a Charity set up in the belief that children could gain huge social benefits by playing in a symphony orchestra. In the community, this was known as the "Big Noise" and it used music making to foster confidence, team work, pride and aspiration in the children taking part and across their wider community. It was hoped that there could be an offshoot set up in Glasgow.
- (iv) On 19 August 2012, Mr Robertson attended the Young Carers Festival in West Linton. This was a fantastic opportunity for all young carers from across Scotland to get together and cultivate friendships, exchange experiences and realise they were not alone in their caring role and to voice their concerns to politicians and providers of services.

NOTED

64. CHIEF EXECUTIVE'S UPDATE

- (i) On 9 July 2012, Mr Calderwood had attended a joint meeting with East Renfrewshire Council to discuss with Ms L Macmillan, their Chief Executive, the financial outlook, community planning, health and social care integration, capital developments and the NHS Board's clinical services review.
- (ii) On 17 August 2012, Mr Calderwood spoke at the Holyrood Summer School at the University of Stirling where he addressed the cohort on "Beyond 2015: the Prospects and Challenges for Health and Social Care"
- (iii) On 20 August 2012, Mr Calderwood met with the Chief Executive of North Ayrshire Council, Ms E Murray, to discuss how Irvine (as an enterprise area with a specific target of growing life sciences) could potentially link with the new build South Side Hospitals.

It was agreed that the NHS Board would facilitate a conference to explore this opportunity further.

**Chief
Executive**

NOTED

65. MINUTES

On the motion of Dr M Kapasi MBE, seconded by Prof A Dominiczak, the Minutes of the NHS Board meeting held on Tuesday 26 June 2012 [NHSGG&C(M)12/03] were approved as a correct record and signed by the Chair.

NOTED

66. MATTERS ARISING FROM THE MINUTES

- (i) The rolling action list of matters arising was noted.
- (ii) In respect of Minute Number 44 - "Healthcare Associated Infection Reporting Template (HAIRT)" - Mr Sime asked that Dr Armstrong's commitment to discuss the monitoring of a zero tolerance approach to non compliance in the hand hygiene of patients be added to the rolling action list. This was agreed and Dr Armstrong confirmed that this had been discussed with the NHS Board's Infection Control Group.
- (iii) In respect of Minute Number 50 - "NHS Greater Glasgow and Clyde's Corporate Plan 2013/2016" - Councillor Lafferty asked if newly appointed NHS Board members would have an opportunity to discuss the Corporate Plan and to learn about the Board's direction of travel for 2013/16. Ms Renfrew confirmed that the Corporate Plan would indeed be further discussed in more detail at the Induction Session for new members on 4 September 2012.

**Medical
Director**

NOTED

67. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 12/33] 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 Armstrong reported that the NHS Board's aim statement was currently being revised to take account of recent changes in the aims of the national programme. Many of the national aims were being reviewed in light of experience as well as new areas of development.

Dr Armstrong reported that the scope of the overall programme continued to be extended and she outlined the main clinical improvement themes in terms of the following programmes:-

- Acute Core Adult
- Acute Paediatric
- Primary Care
- Mental Health

- Specialist (such as heart failure, sepsis and venous thromboembolism)
- Maternity Care

Dr Armstrong led the NHS Board through the scale of activities associated with these programmes and described the challenge in capacity and support to sustain the SPSP in NHS Greater Glasgow and Clyde.

In response to a question from Dr Benton regarding one of the two new aims which was to ensure that at least 95% of people who received care did not experience harm (such as infections, falls, blood clots and pressure sores), Dr Armstrong reported that ongoing discussions were taking place with the Scottish Government Team to determine the baseline for this as it was paramount to be clear on what was being measured. Mrs Spencer agreed that it would be important to be clear about what this target actually meant particularly as areas such as falls had a significant morbidity both in the community and acute sectors.

Dr Kapasi asked about optimum glucose control and its application in primary care. Dr Armstrong explained that this element was still being developed for use in acute care for people with Type 2 diabetes.

In response to a question from Mr Sime, Dr Armstrong confirmed that SPSP represented the first country-wide implementation of such a programme. As such, there had been significant interest from other health organisations UK-wide and from Europe.

Mr Williamson reported that infection was the most common form of morbidity in some surgical procedures. As such, the priority should be to reduce Surgical Site Infection (SSI) rates for all procedure categories. Dr Armstrong agreed and confirmed that the new IT system would help analyse this information. She would update on progress.

**Medical
Director**

In terms of the other new aim to reduce the Hospital Standardised Mortality Ratio (HSMR) by 20% by 2015, Councillor Rooney asked how many people this represented and how to reduce it further. Dr Armstrong reported that it was difficult to quantify a figure. In order to reduce further, the aim was to look at high risk areas, clinical incidents, avoidable events and early warning scores to methodically measure outcomes.

NOTED

68. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 12/34] asked the NHS Board to note the latest in the regular bi-monthly reports on Healthcare Associated Infection (HAI) in NHS Greater Glasgow and Clyde.

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

In 2007 the SGHD issued a Local Delivery Plan (LDP) HEAT target in relation to Staphylococcus aureus Bacteraemias (SABs) in which NHS Greater Glasgow and Clyde successfully reduced SABs by 35% by April 2010. This target was extended by an additional 15% reduction which was also successfully achieved by 31 March 2011. For the last available reporting quarter (January to March 2012) NHSGGC reported

0.275 cases per 1000 acute occupied bed days (AOBDs). NHS Scotland reported 0.292 per 1000 AOBDs. The revised national HEAT required all NHS Boards in Scotland to achieve a rate of 0.26 cases per 1000 (AOBDs) or lower by 31 March 2013. Subsequent HAIRT reports would update on the NHS Board's progress towards meeting this challenging target.

The national report published in July 2012 (January to March 2012) showed the rate of C.difficile within NHSGGC as 0.25 per 1000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean (0.28 per 1000 OBDs in over 65s) and also below the revised HEAT target for patients aged 65 and over, to be attained by 31 March 2013 of 0.39 cases per 1000 total occupied bed days. Subsequent HAIRT reports would update on progress towards this target.

Surgical Site Infection (SSI) rates for all procedure categories, apart from reduction of long bone fracture, remained below the national average.

The Cleanliness Champions Programme was part of the Scottish Government's Action Plan to combat HAI within NHS Scotland. To date, NHSGGC had supported 2,760 members of staff who were now registered as Cleanliness Champions.

Dr Armstrong took members through the rest of the report focussing on hand hygiene, cleaning and the healthcare environment, outbreaks and other HAI related activity.

She confirmed that 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 95% reported in July 2012. Hand hygiene compliance audits were carried out on a monthly basis in the majority of wards and departments in NHS Greater Glasgow and Clyde. This information was used at a local level to tackle issues that may affect staff practice. Furthermore, it was her intention to plan a campaign to promote better hygiene amongst visitors. She hoped to work up a proposal to encourage visitors to wards to use a hand gel product located at ward entrances. She would keep the NHS Board up to date with this development.

**Medical
Director**

Mrs Grant alluded to the Healthcare Environment Inspectorate (HEI) unannounced inspection at the Vale of Leven Hospital on 7 June 2012. Arising from that, three requirements and two recommendations had to be actioned locally.

Dr Benton noted that although infections were mostly associated with being treated in hospitals, they could arise from community sources such as GP Surgeries, care homes and hospices. Although there was a section to cover "out of hospital infections" in the NHS Board paper she wondered if it was possible to be more specific about the analysis of data arising in nursing homes. Dr Armstrong reported that the project had not yet reported. She undertook to bring back a report when it was ready.

**Medical
Director**

In response to a question from Councillor Rooney, Dr Armstrong confirmed that the NHS Board's SSI rate for caesarean sections was below the national average.

Ms Micklem asked about the hand hygiene monitoring compliance information as shown for the Vale of Leven Hospital. This was reported as 100% for June 2012 yet, the HEI unannounced visit held on 7 June 2012 had been critical of hand hygiene compliance. Mrs Grant confirmed that monitoring took place on a monthly basis across the majority of wards and departments. There were occasions when medical staff did access hand gel behind curtains after examining patients and, therefore, out of sight of the Inspectors and this was not recorded as complying with hand hygiene standards.

Every effort would be made to ensure maximum compliance with these standards in future.

NOTED

69. INTEGRATED PREVENTION FOR LONG TERM CONDITIONS

A report of the Director of Public Health [Board Paper No. 12/35] asked the NHS Board to note the key role of preventable long term conditions to NHS Greater Glasgow and Clyde's sizable burden of poor health, premature mortality and inequalities and approve the NHS Board's strategic approach to anticipatory care.

Dr de Caestecker introduced the update on NHS Greater Glasgow and Clyde's integrated prevention programmes for long term conditions in 2011/12 explaining that the NHS, in common with other public services, faced enormous fiscal challenges. Operating in such an environment required a clear focus on the factors that represented the biggest challenges to population health and delivering interventions that offered strongest evidence of effectiveness in addressing these in the most effective way. She introduced Dr A Scoular, Consultant in Public Health Medicine, to quantify the central importance of long term conditions to NHS Greater Glasgow and Clyde's sizable burden of poor health, premature mortality and inequalities; to demonstrate their enormous prevention potential; and to provide an overview of the NHS Board's current programme of preventative interventions for long term conditions.

Dr Scoular explained that the primary purpose of NHS Greater Glasgow and Clyde was to enable its population to live longer, healthier lives. Two key outcome measures showed how successful the Board was in achieving these objectives; life expectancy (an estimate of how long the average person might be expected to live) and healthy life expectancy (an estimate of how many years they were expected to live in a "healthy" state). The gap between both indicated the length of time spent in a "not healthy" state. A third aim for all health care systems was to try to increase the healthy life expectancy to bring it as close as possible to life expectancy, thereby, reducing the time period over which people lived in poor health.

Dr Scoular explained that average life expectancy in NHS Greater Glasgow and Clyde, although rising, was the lowest in Scotland and among the lowest in Europe. Deaths were considered to be premature when they occurred before the usual age of death; in Scotland, this was defined as 75. Not only did NHS Greater Glasgow and Clyde residents have, on average, shorter lives compared with other Scottish residents, but they also spent more years in ill health. The combined effect of early deaths and many years lived in poor health was called "burden of disease", expressed in Disability Adjusted Life Years (DALYS). This allowed the understanding of the specific conditions which had the greatest impact on population health, informing prioritisation of resources.

Premature mortality, poor health and unfavourable health related lifestyles were not uniformly distributed across NHS Greater Glasgow and Clyde but were clustered within certain population sub-groups, particularly among those living in the most deprived areas. Deprivation was not the whole story, however, the likelihood of experiencing a long term condition increased steeply with age and communities with higher proportions of older people were often less deprived.

As such, this had to be taken into account as well as deprivation when planning services for long term conditions prevention and care.

Dr Scoular led the NHS Board through the report highlighting that the Board's disease burden was highly preventable and illustrated how the impact of long term conditions could be reduced with well integrated primary, secondary and tertiary prevention programmes.

She concluded by explaining that tackling the NHS Board's burden of preventable ill health, and its resultant demand on health care services, would require the balance of spend to be shifted in favour of prevention, not just more spending on health care. Currently only 3/4% of total NHS expenditure was currently allocated to population wide prevention and public health programmes with most spending focussed on "illness care" services. The integrated prevention programme she described explicitly identified the synergistic clinical, health improvement and public health actions required to achieve this.

Dr de Caestecker added that within this strengthened approach to prevention, it was vital that NHS Greater Glasgow and Clyde maintained a clear focus on achieving concerted "whole system" action on the risk factors that made the biggest contribution to the total burden of disease and to the socially determined inequalities in health status. NHS Greater Glasgow and Clyde should clearly prioritise NHS interventions that offered strongest evidence of effectiveness in addressing preventable risk factors for long term conditions.

There was much debate around the content of the paper with NHS Board members agreeing it articulated a mechanism for driving further improvements in locally relevant primary prevention strategies with much wider transferrable learning for improving preventive health care. Professor Dominiczak reiterated that prevention was better than cure encouraging further link-up between secondary prevention and academia. Dr Scoular agreed that connectivity was vital and alluded to much of the sterling work undertaken to date by the Managed Clinical Networks (MCNs).

Ms Micklem appreciated the work of the paper and its huge strategic challenge for the future. She noted the amount of resources devoted to prevention and wondered what would be tackled first if that balance shifted. Dr Scoular responded by confirming that the NHS Board had a road map of priorities and agreed that, to increase sustainability, it was paramount to work closely with partners including local authorities and voluntary and community organisations.

Ms Brown referred to the inequalities issues highlighted by the report and the need to advocate for change at a societal level as life choices and lifestyles were significant contributory factors to ill health. Mr Carson agreed that the environment and society played a significant part in overall life expectancy, general health and wellbeing.

Ms Renfrew highlighted the need to understand the NHS's role in the prevention of long term conditions and what exactly NHS Greater Glasgow and Clyde was able to contribute. Given the level of debate around the issues, she suggested setting time aside at a future Board seminar session to talk this through in further detail. This approach was welcomed.

**Head of Board
Administration**

DECIDED

- That the key role of preventable long term conditions to NHS Greater Glasgow and Clyde's sizable burden of poor health, premature mortality and inequalities be noted.
- That NHS Greater Glasgow and Clyde's strategic approach to anticipatory care be approved.

**Director of
Public Health**

- That the update on NHS Greater Glasgow and Clyde's integrated prevention programmes for long term conditions in 2011/12 be received.

70. AUDIT SCOTLAND – ANNUAL REPORT ON THE 2011/12 AUDIT

A report of the Director of Finance [Board Paper No. 12/36] asked the NHS Board to note the “Annual Report on the 2011/12 Audit” as issued by the external Auditors, Audit Scotland, on the audit of NHS Greater Glasgow and Clyde.

Ms Woolman set out the report which looked at the key strategic and financial risks being faced by NHS Greater Glasgow and Clyde, audited the financial statements and reviewed the use of resources and aspects of performance management and governance. She reported that the Board had been given an unqualified opinion on its financial statements. Audit Scotland had also concluded that, in all material aspects, the expenditure and receipts shown in the financial statements were incurred or applied in accordance with applicable enactments and relevant guidance issued by Scottish Ministers.

Ms Woolman led the NHS Board through a summary of the audit which included the following:-

- Financial position and use of resources
- Partnership working
- Governance and accountability
- Performance

In terms of looking forward, Ms Woolman noted some key risk areas for the NHS Board. There would be limited increase in funding, increasing cost pressures in respect of prescribing growth and utility costs and challenging savings targets. To achieve continuing financial balance, the NHS Board would require to deliver £59m of recurring cost savings in 2012/13. Expenditure during the year would require to be closely monitoring to identify and address any emerging budget pressures or projected overspends at an early stage.

In response to a question, Ms Woolman reported that the significant financial challenges that the NHS Board would face in 2012/13 and beyond would require the NHS Board to prioritise further its use of resources. This would make maintaining, or improving, on the performance targets set by the Scottish Government even more challenging. Furthermore, the completion of the new South Side Glasgow Hospitals in 2015 (and the continued implementation of redesign strategies) would require changes to be made in the numbers and skill mix across all professions. It was essential, therefore, that effective workforce planning was in place which took account of this and any future reconfiguration of services and was applied in such a way to ensure that staff morale was not adversely affected.

It was noted that although the Audit Committee was aware of the content of Audit Scotland's report, it had not formally been considered by members at a meeting.

As such, it was agreed that, in October 2012 and in future years, the external auditors report be considered by the Audit Committee prior to the NHS Board.

**Head of Board
Administration**

NOTED

71. NHS GREATER GLASGOW AND CLYDE - ANNUAL REVIEW OF GOVERNANCE ARRANGEMENTS

A report of the Head of Board Administration [Board Paper No. 12/37] asked the NHS Board to approve, note and agree any revisions to the governance arrangements in place within NHS Greater Glasgow and Clyde.

Mr Hamilton reminded the NHS Board that, in February 2005, it approved the new organisational arrangements to implement the white paper "Partnership for Care". Subsequently, two significant reviews of the governance arrangements had taken place as the moves to single system working and integration of Clyde were carried out and, as a result, the NHS Board approved in December 2006, a detailed set of new governance arrangements to support the new organisation.

In response to the launch of the Quality Strategy and the need to embed its requirements within corporate reporting and governance structures, the NHS Board had considered an integrated approach to performance reporting and established the Quality and Performance Committee from July 2011 to carry out these functions.

An annual review of corporate governance arrangements was normally carried out in April each year. With the local authority elections being held in May 2012, however, it was agreed to hold back the review until August 2012 in order that the newly appointed councillors (and the two non executive members appointed on 1 May 2012) could be included within the membership of standing committees of the NHS Board. It also had the added advantage of allowing the Chair to consider members comments during the annual appraisal process and allow these to be reflected in the outcome of some changes to the membership of some of the standing committees.

Lastly, Mr Hamilton reported that this year's review had not included the outcome of the review of Standing Financial Instructions (SFIs). The Director of Finance was carrying out a fundamental review of the SFIs and schemes of delegation and intended that his final report and recommendations be submitted to an NHS Board meeting later in the calendar year for consideration.

Director of Finance

Mr Hamilton led the NHS Board through the changes which provided a solid governance framework for the NHS Board properly to discharge its responsibilities and statutory functions.

DECIDED

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|---|-------------------------------------|
| (i) That the Standing Orders for the Proceedings and Business of the NHS Board and the Decisions Reserved for the NHS Board [Appendix 1] be approved. | Head of Board Administration |
| (ii) That the remits of the Standing Committees – Quality and Performance Committee [Appendix 2], Audit Committee [Appendix 3], Pharmacy Practices Committee [Appendix 4] and Area Clinical Forum [Appendix 5] be approved. | Head of Board Administration |
| (iii) That the memberships of the Standing and Subcommittees [Appendix 6] be approved. | Head of Board Administration |
| (iv) That the membership of the Adults with Incapacity Supervisory Body [Appendix 7] be approved. | Head of Board Administration |
| (v) That the list of Authorised Officers to sign Healthcare Agreements and related contracts [Appendix 8] be approved. | Head of Board Administration |

72. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer [Board Paper No 12/38] asked the NHS Board to note progress against the national targets as at the end of June 2012.

Mrs Grant led the NHS Board through the report highlighting the actions being taken to deliver the waiting times and access targets. This included general waiting times/18 weeks referral to treatment (RRT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. She also referred to delayed discharges.

In response to a question from Ms Brown regarding the unavailability figures for Yorkhill Hospital, Mrs Grant reported that the unavailability of patients across the division had been closely monitored as the waiting times and number of unavailable patients had reduced over the past year. Yorkhill, however, saw seasonality issues with an increase in patients being unavailable to attend in-patient/daycase and out-patient appointment during periods such as Easter, summer holidays and Christmas/New Year holidays. Councillor Rooney asked for more information on what "unavailable" meant. Mrs Grant explained how this was applied and the variety of reasons it could include, such as, patient holidays, patient being medically unfit/unavailable at the time an appointment was made, a patient declining an offer of treatment at a particular site and/or patient declining an offer to see a particular consultant.

In response to a question concerning patients awaiting discharge, Mrs Grant confirmed that, in order to ensure patients received the most appropriate care (and to ensure that capacity was available for new admissions), it was imperative that patients were discharged as soon as they were clinically ready. This work was the principle focus of joint planning with local authorities regarding older people and was supported by the additional "change funds" released this year to the NHS Board. Initiatives supported by these funds were now starting to be put in place and early improvements were now starting to be delivered.

NOTED**73. FINANCIAL MONITORING REPORT FOR THE 3 MONTH PERIOD TO 30 JUNE 2012**

A report of the Director of Finance [Board Paper No. 12/39] asked the NHS Board to note the financial performance for the first three months of the financial year.

Mr James explained that the NHS Board was currently reporting an expenditure outturn of £0.9m in excess of its budget for the first three months of the year. At this stage, however, the NHS Board considered that a year end breakeven position remained achievable.

Mr James led the NHS Board through further information in relation to expenditure in acute services, NHS partnerships and corporate services. During the next few months, the NHS Board would work to confirm the extent to which its operating directorates could offset additional expenditure against budget through catch up in implementing existing cost reduction/cost saving measures and use of in year slippage against expenditure budgets. This work would be completed by October 2012 so that the NHS Board was able to assess, at that stage, whether it remained on track to deliver a breakeven outturn for 2012/13.

In response to a series of questions from Councillor Rooney, it was agreed that further discussion and breakdown of the key figures and comments be provided at the new members' Induction Session for 4 September 2012.

**Director of
Finance**

Councillor Handibode commended the report which he considered to be well laid out and provided the key encouraging message to the NHS Board which gave every confidence that breakeven would be achieved.

NOTED

**74. 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. 12/40] 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 sixteen 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**

75. AREA CLINICAL FORUM MINUTES: 7 JUNE 2012

The Minutes of the Area Clinical Forum meeting held on 7 June 2012 [ACF(M)12/03] were noted.

NOTED

76. AUDIT COMMITTEE MINUTES: 19 JUNE 2012

The Minutes of the Audit Committee meeting held on 19 June 2012 [A(M)12/04] were noted.

NOTED

**77. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 20 MARCH 2012
AND 15 MAY 2012**

The Minutes of the Quality and Performance Committee meeting held on 3 July 2012 [QPC(M)12/04] were noted.

NOTED

The meeting ended at 11:45am