NHSGG&C(M)12/06
Minutes: 96 - 115

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, 18 December 2012 at 9:30a.m.**

PRESENT

Mr A O Robertson OBE (Chair)

Dr J Armstrong
Dr C Benton MBE
Ms M Brown (to Minute No 107)
Dr L de Caestecker
Mr R Calderwood
Ms R Crocket
Prof A Dominiczak (to Minute No 103)
Mr R Finnie
Mr I Fraser
Councillor J Handibode
Mr P James
Dr M Kapasi MBE
Councillor A Lafferty
Mr I Lee
Councillor M Macmillan (to Minute No 109)
Councillor J McIlwee
Ms R Micklem
Councillor M O'Donnell
Dr R Reid
Councillor M Rooney
Mr D Sime
Mrs P Spencer
Mr B Williamson
Mr K Winter

IN ATTENDANCE

Mr G Archibald	Director of Emergency Care and Medical Services (for Minute No 106)
Ms S Gordon	Secretariat Manager
Ms 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
Mr I Reid	Director of Human Resources
Ms C Renfrew	Director of Corporate Planning and Policy
Dr M Smith	Lead Associate Medical Director (Mental Health) (for Minute No 105)

ACTION BY

96. APOLOGIES

Apologies for absence were intimated on behalf of Mr G Carson, Mr P Daniels OBE, Councillor M Kerr and Rev Dr N Shanks.

NOTED

97. 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

98. CHAIR'S REPORT

(i) Mr Robertson attended two awards ceremonies; the first one on 29 October 2012 at the University of Glasgow presenting the Excellence in Education awards to University staff as well as NHSGGC's own clinicians. He was accompanied by Professor Dominiczak and reported that this was the first event of its like which would hopefully be repeated as it showed great appreciation to University and NHS Board staff alike. Secondly, on 30 October 2012, he attended the SVQ Qualifications awards ceremony at the Beardmore Hotel for NHSGGC staff. For many, this was their first qualification and he had been very impressed with their level of commitment.

(ii) On 2 November 2012, Mr Robertson attended the opening of the new Cancer Support Scotland Centre in the old Gartnavel chapel. He commended this service and particularly the excellent use of a redundant building within the Gartnavel Hospital campus.

(iii) On 6 November 2012, Mr Robertson attended the opening of the refurbished Dental Hospital clinics and the official opening of the Dorothy Geddes Multi Media Teaching Laboratory. He was very impressed with the resourceful design, in a difficult environment, of this accommodation.

(iv) On 7 November 2012, Mr Robertson cut the turf at Leverndale Hospital for a new build acute admissions unit that would replace an existing facility currently provided on the Southern General Hospital campus to new mothers and babies suffering severe mental illness following the birth of their baby. This impressive new facility would bring state of the art health care to the local community. It also marked another significant step forward in the modernisation of mental health provision in NHS Greater Glasgow and Clyde.

(v) On 8 and 9 November 2012, Mr Robertson attended the Scottish Patient Safety Programme (SPSP) sessions held at the SECC. This event was well attended by non executive NHS Board members and staff and had been worthwhile in looking at a lot of the detail and governance issues taking the Programme forward.

(vi) On 14 November 2012, Mr Robertson attended the official opening, by the Cabinet Secretary, Alex Neil, MSP, of the new £90M laboratory on the new South Glasgow Hospital campus. The laboratory was part of the £842M publically funded new South Glasgow Hospitals which would see an integrated children's and adult hospital built on the site.

(vii) On 26 November 2012, the Cabinet Secretary, Alex Neil MSP, hosted the NHS Board's Annual Review. Although the formal follow up letter was still to be received, general feeling had been that the event had been positive, not only between the NHS Board and the Cabinet Secretary but with members of the public.

(viii) On 11 December 2012, Mr Robertson attended the launch of the first NHS Scotland pregnancy and parenting smart phone app. This app made it quicker and easier for women and their partners who were trying for a baby, pregnant or new parents to find information they could trust. It was a collaboration between NHS Health Scotland and NHSGGC and was personalised and portable giving women advice at their fingertips.

NOTED

99. CHIEF EXECUTIVE'S UPDATE

On 30 November 2012, Mr Calderwood visited Homerton University Hospital NHS Foundation Trust in London to learn lessons from the city having hosted the Olympic Games in preparation for Glasgow hosting the Commonwealth Games in 2014. This had provided an insight into the planning and delivery of associated health services which had been most useful.

NOTED

100. MINUTES

On the motion of Dr R Reid, seconded by Dr M Kapasi MBE, the Minutes of the NHS Board meeting held on Tuesday, 16 October 2012 [NHSGG&C(M)12/05] were approved as a correct record and signed by the Chair.

NOTED

101. MATTERS ARISING FROM THE MINUTES

The rolling action list of matters arising was noted.

NOTED

102. SCOTTISH PATIENT SAFETY PROGRAMME UPDATE

A report of the NHS Board's Medical Director and Head of Clinical Governance [Board Paper No 12/50] asked the NHS Board to review and comment on the ongoing progress achieved by NHS Greater Glasgow and Clyde in implementing the Scottish Patient Safety Programme (SPSP).

Dr Armstrong led the NHS Board through the feedback report from the visit by the SPSP National Team as part of the National Review. She shared this with the NHS Board acknowledging that there were still many challenges in meeting safety aspirations but highlighted that this report represented the feedback from independent observers in recognising the progress staff had made to date.

The visit took place on 8, 9 and 10 October 2012 and its purpose was to collate learning of good practice from the first phase of the Programme, identify areas of success and factors leading to that success, look at spread of interventions within NHS Boards and identify themes for focus of the next phase of the Programme.

Dr Armstrong summarised four of the key findings from the visit and highlighted the successes and challenges associated with them as follows:-

- The complexity of the NHS Board's size and range of services was evident with discussions with the clinical teams and the patient safety co-ordination teams, which comprised over 300 wards and seven intensive care areas. The pre-operative workstream was an example of the complexity with ten sites, 12 surgical speciality groupings and 50 theatre teams.
- Evidence of enthusiasm and motivation for patient safety and quality improvement within NHSGGC.
- Extremely well thought out and planned safety team structure to support the clinical teams with clear conduits to seek support and guidance. A close relationship with each of the SPSP programme managers and the clinical risk management teams existed.
- Passionate leaders who were aware of the demands on clinical staff to deliver excellent clinical care whilst trying to balance the competing demands of multiple data collection, recording and reporting.

Mr Williamson congratulated Dr Armstrong and her staff for the vast progress made since the introduction of SPSP. He was proud to note that the NHS Board's staff were so enthusiastic at the front line and stressed the importance of building on this momentum to innovate for the future. Mrs Micklem agreed and acknowledged the recognition of some of the more bureaucratic aspects to SPSP and what could be done about this in the future. She asked how evidence of good practice within NHSGGC could be used by other NHS Boards. Dr Armstrong confirmed that all Scottish NHS Boards shared learning in respect of SPSP and she alluded to the national event held on 8 November 2012 at the SECC. She was hopeful that as the Programme developed, however, shared learning would do likewise.

In response to a question concerning the growing awareness of the harm caused by delirium and the scrutiny of associated patient assessment and treatment, Dr Armstrong confirmed that confusion and/or delirium could be a sign of developing a complication or infection in a patient. As such, the earlier this was picked up by clinicians the better. Assessment of a patient's neurological function presented a whole raft of purposes and was key to improving critical care outcomes.

In response to some questions concerning the LANQUIP Data collection system which NHSGGC had also adopted, Dr Armstrong alluded to its challenges. The system did not offer the flexibility that was required for NHS Board-wide reporting though did allow local data entry. Currently, local teams were using a combination of local excel spreadsheets and LANQUIP. The teams were planning to discuss local NHSGGC modifications to LANQUIP to make it fit for purpose within the NHS Board's area.

Dr Armstrong reported that since the introduction of SPSP five years ago, 309 walkarounds had been completed with 931 associated actions required. 70% of these actions had been completed with the remaining 30% ongoing. Mrs Grant described the process of a walkaround which included speaking to staff, inspection of the clinical area and discussion with staff around safety concerns, near misses, best practice and local learning and actions. The walkarounds had been seen as a very positive development for management and staff alike.

In response to a question from Councillor Handibode concerning the APACHE score, Dr Armstrong explained that this was used in critical care units across Scotland to measure how ill a patient was. It was regularly used to compare data across NHS Board areas in Scotland to understand local mortality rates.

NOTED

103. HEALTHCARE ASSOCIATED INFECTION REPORTING TEMPLATE (HAIRT)

A report of the NHS Board's Medical Director [Board Paper No 12/51] 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 (April to June 2012), NHSGGC reported 31.2 cases per 100,000 Acute Occupied Bed Days (AOBDs). NHS Scotland reported 30.2 per 100,000 AOBDs. The revised national HEAT required all NHS Boards in Scotland to achieve a rate of 26 cases per 100,000 (AOBDs) or lower by 31 March 2013.

The national report published in October 2012 (April to June 2012) showed the rate of C.difficile within NHSGGC as 25.1 per 100,000 occupied bed days in over 65s. This clearly placed the NHS Board below the national mean (30.8 per 100,000 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 39 cases per 100,000 total occupied bed days.

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 2,824 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 referred to the peak in Norovirus activity seen since October 2012. Increased activity was such that daily reporting took place. At its worst, in early December 2012, 15 wards had been closed due to confirmed or suspected Norovirus. This was being monitored closely but Dr Armstrong reported that, as of 17 December 2012, no wards were closed.

In response to a question from Councillor O'Donnell concerning hand hygiene, Dr Armstrong reported that hand hygiene compliance audits were carried out on a monthly basis in the majority of wards and departments in NHSGGC. The September 2012 Health Protection Scotland (HPS) report showed a current figure of 96% hand hygiene compliance by staff. In terms of good hand hygiene by visitors, she agreed this was key and alluded to an audit undertaken to study visitor behaviour patterns in respect of hand hygiene. As a result of this work, a process would be designed to try to increase compliance and highlight the importance of good hand hygiene as a way to prevent the spread of infections.

Referring to earlier comments made about the spike in Norovirus in the last few months, Dr Kapasi asked how this was tackled at hospital level. Mrs Grant explained the impact of such ward closures on resources and capacity planning and emphasised that early action was taken to minimise hospital/ward upheavals. Patients confirmed as having Norovirus were placed in isolation wards, where possible. Although this

group of patients were clustered together she emphasised that clinical care was always appropriate to individual patients.

NOTED

104. UPDATE ON PROGRESS WITH RECOMMENDATIONS FROM THE DIRECTOR OF PUBLIC HEALTH: KEEPING HEALTH IN MIND

A report of the Director of Public Health [Board Paper No. 12/52] asked the NHS Board to note progress on the recommendations from the report of the Director of Public Health on the mental health of the population of NHSGGC 2011-13.

Dr de Caestecker explained that her report focused on mental health because it was crucial to improving health and well being. The aims of the report were to put mental health into perspective and take a life course approach from early years to older people. The report highlighted the work of NHSGGC and its partners and placed emphasis on early intervention, resilience and approaches to support the promotion of positive mental health. She led the NHS Board through the progress made so far and recommendations which reflected the chapter headings of the original report as follows:-

- Mental Health was important
- Early years
- Children and Young People
- Mental Health and well being of adults
- Older Health

Dr de Caestecker reported that she would submit her next bi-annual report (2013-15) to the NHS Board in autumn 2013. This report would look at poverty and health inequalities across the generations but would also include a further update of the recommendations reported on the mental health elements.

In response to a question from Dr Kapasi, Dr de Caestecker reported that all pregnant women were carbon monoxide tested at antenatal bookings whether they smoked or not.

Ms Micklem commended all the activity but asked how measurement would take place to identify what was having the best effects in terms of resources and outputs. Dr de Caestecker explained that evaluation was key and all new services/proposals would be evaluated. Outcome measures were being set nationally and, in recognition of the difficulties in measuring mental health, work would be undertaken with the voluntary sector to ensure that services were developed that built on clinical relationships and mental health needs.

Following up this point, Ms Brown referred to the low up take in the preconception and perinatal mental health service. She considered there to be scope for mainstreaming such services particularly as good mental health was everyone's responsibility. As such, she suggested that improving the mental health of the population played a key role in the NHS Board's current Clinical Services Review.

Councillor Handibode referred to the welfare reforms due to be implemented on 1 April 2013 and cautioned about people's level of understanding of the ramifications of these reforms. It may be that this would have an impact on the use of local mental health services. Dr de Caestecker agreed and reported that local NHS frontline staff should have the knowledge to refer patients to agencies for money/debt advice.

Councillor Lafferty welcomed this approach and acknowledged the challenges that lay ahead and the scale of the problem for members of the public and organisations in an effort to rebuild communities.

Councillor Macmillan emphasised the need to look at employability issues in terms of the NHS Board's role as an employer and in supporting patients who accessed mental health services to get back into employment. Mrs Hawkins agreed and outlined the role of the NHS Board's Health and Employability Steering Group which primarily looked at staff health, reducing sick leave, rehabilitation programmes and health checks. She also referred to the many health benefits resulting in people being in employment and how the NHS Board was actively influencing community planning processes to articulate this.

Mrs Spencer referred to the NHS Board's Physical Health Care Policy which she regarded, from a clinical point if view as being laboured but essential. What was important to staff in terms of measuring outcomes must also balance what a patient regarded as personal progress.

NOTED

105. SUICIDE PREVENTION IN GREATER GLASGOW AND CLYDE

A report of the Director of Public Health [Board Paper No. 12/53] asked the NHS Board to note the contents of the suicide prevention update paper particularly the work of the recently formed Suicide Prevention Group as well as noting the development work that would lead to the comprehensive programme and workplan for suicide prevention aimed for completion in Spring 2013.

Dr Smith explained that suicide was a challenging and complex mental health issue which had strong associations with deprivation. As such, it required concerted and sustained effort from a wide range of partners. Despite some declines in suicide rates for Greater Glasgow and Clyde over the last decade, he reported that this had been modest compared with national and international trends. An NHSGGC Suicide Prevention Group had been formed, incorporating different NHS clinical areas, wider partners including the police and voluntary sectors and from the six Choose Life programmes within the NHS Board area. A number of subgroups and workstreams were progressing, including further development work around self harm training, a focus on strengthening community prevention approaches, work to enhance mental health related triage in emergency medicine settings and to apply local and UK-wide learning from significant clinical incident reporting.

Dr Smith led the NHS Board through a brief overview of these key development areas explaining that these would be utilised to create a comprehensive workplan with identified leads for implementation. Links would be maintained with the Scottish Government's Mental Health Division and the national Choose Life programme to ensure alignment with national policy developments.

In response to a question from Councillor O'Donnell, Dr Smith confirmed that, while there had been a welcome decline in suicide rates in Greater Glasgow and Clyde over the last decade, this had been more modest than for Scotland as a whole. Furthermore, Scotland's rate for suicide was still approximately 80% higher than in England and Wales. The reasons for this were unclear but the measurement of risk in those having suicidal thoughts was essential.

Mrs Spencer referred to the ongoing training of frontline staff in suicide assessment and intervention skills. Dr Smith reported that, although the national HEAT target had been met, GPs and A & E staff did not find the current suicide prevention

training materials and format suitable to their needs. Accordingly, work had begun with educational and learning colleagues to develop new materials that were relevant to those groups and could be delivered in clinical settings. He explained that this was likely to involve a brief intervention to staff groups in the workplace supported by online material and the availability of longer training sessions.

Dr Benton emphasised the importance in ensuring there was no delay in patient referral from a GP to a psychiatric service for those with such a need. Dr Smith agreed and reported that work was ongoing to reduce waiting times where they could.

Ms Brown suggested that, given the impact of social disadvantage, generally, it may now be necessary to rebalance the provision of mental health services and increase availability to services tackling mild to moderate mental health issues. Mr Williamson agreed and welcomed the suggested innovation to improve current services particularly in relation to looking at methods of complementing the use of "actuarial" methods currently in practice.

Mr Finnie referred to the Fatal Accident Inquiry into the circumstances of the deaths of two young girls from the Erskine bridge in October 2009. Mrs Hawkins reported that the Sheriff's recommendations were not directly for the NHS but that NHS Board colleagues had scrutinised the report to identify any ongoing lessons to be learned.

Dr Smith agreed with a point made by Dr Kapasi in that men were more likely to succeed in suicide. There were many socio-economic factors for this but it had been found that having responsibility for children often stopped a successful suicide.

Dr Smith confirmed that that this paper would be considered by each of the NHS Board's CH(C)Ps.

NOTED

106. WINTER PLAN – 2012/13

A report of the Director of Emergency Care and Medical Services [Board Paper No. 12/54] asked the NHS Board to note the Winter Plan 2012/13.

Mr Archibald provided an overview of the plans of each of the partner agencies across Greater Glasgow and Clyde to ensure preparedness for 2012/13. To support the Winter Plan, there was an escalation plan, with each agency having its own local plans. It was recognised, at both a local and national level, that winter planning was now all year planning and not just aligned to the months November – March. The principles outlined in the Winter Plan highlighted the actions required to manage surges in demand across the system as per the escalation plans for each agencies. Mr Archibald confirmed that a copy of the plan would be made available on the NHS Board's website.

In response to a question from Mrs Spencer, Mrs Hawkins reported that the NHS Board now had in place a single discharge team which linked in with each of the partner agencies through the localities to manage the discharge planning. This had improved access to services and the joint working was supporting earlier discharge from hospital to reduce length of stay. Furthermore, arrangements had been made for the provision of nursing home beds in the east end of Glasgow where GPs would visit patients there. It would be important to learn lessons from this initiative as this was the first time that services had been arranged this way.

Councillor O'Donnell commended the joint working and linkages that had taken place between local authorities and the NHS in taking forward Winter Planning. Many challenges were also recognised particularly around discharge planning and adequate transport provision and many lessons had been learned from the winter two years ago when conditions were very extreme and services challenged.

In response to a question from Councillor Rooney, concerning the need for local authorities to reduce their winter maintenance budget, Mr Archibald confirmed that if the NHS became aware of patterns or trends of patient trips/slips and falls from a particular local authority area, they would contact them directly to advise of this.

NOTED

107. CLINICAL SERVICES FIT FOR THE FUTURE: A CASE FOR CHANGE

A report of the Medical Director [Board Paper No 12/55] asked the NHS Board to approve the case for change.

Dr Armstrong described the Clinical Services Fit for the Future programme which looked at the shape of clinical services beyond 2015 to make sure the NHS Board could adapt to future changes, challenges and opportunities. She described the key aims of designing a new strategy and how the first stage of the programme had focused on what needed to change in the future to make sure that it could be achieved. The case for change had been developed through the work of 8 clinically led groups which had involved patient representatives and had been supported by wider patient reference groups, involving patients, carers and voluntary groups. She outlined the focus of the groups describing how their work had been supported by extensive literature reviews, activity analysis and population health analysis as well as by a wide programme of engagements with key stakeholders.

During September, October and November 2012, there had been extensive engagement on the case for change and general feedback was that the following nine themes were felt to accurately reflect the range of pressures and opportunities facing the NHS Board in the future:-

1. The health needs of our population were significant and changing.
2. We needed to do more to support people to manage their own health and prevent crisis.
3. Our services were not always organised in the best way for patients.
4. We needed to do more to make sure that care was always provided in the most appropriate setting.
5. There was growing pressure on primary care and community services.
6. We needed to provide the highest quality specialist care.
7. Increasing specialisation needed to be balanced with the need for co-ordinated care which took an overview of the patient.
8. Healthcare was changing and we needed to keep pace with best practice and standards.
9. We needed to support our workforce to meet future changes.

Dr Armstrong led the NHS Board through further detail of these nine themes and set out some key messages and specific examples from the clinical groups. In terms of next steps, she reported that the case for change was an important milestone in the clinical services fit for the future programme. It formed the basis of the next two stages which were:-

- The development of service models. Each of the clinical groups was currently working on the patient pathways and service models the NHS Board would require in future to meet best practice, clinical standards and improved patient outcomes.
- Developing options to deliver new service models. Once the service models were developed, the NHS Board would model the implications of these and how they could best be delivered with resources, infrastructure and workforce expected to be available.

Mr Calderwood pointed out that, as yet, the review had presented no conclusions or proposals. Its purpose, so far, was to let the working groups test current services and this would continue until late Spring/early Summer 2013 covering a broad range of issues. Thereafter, the drivers that could underpin the choices would be identified as well as probing challenges and building on best practice.

Ms Brown thanked Dr Armstrong and her colleagues for such an intelligent and purposeful report. Councillor Rooney agreed and suggested that it be distributed to all CH(C)Ps for further discussion. He suggested that it may be useful to add sections on the economic, national policy and political arena in Scotland as these all had an impact on planning services for the future. Mr Calderwood agreed that this may be added to future versions of the review reporting but, at this stage, a conscious decision had been made not to include finance/resources at the forefront of the review. It had purposely been decided to add this following the debating stage and when the programme moved on to sustainability/affordability. **Medical Director**

In response to a question from Ms Micklem, Dr Armstrong agreed that in all nine key workstreams, there was a common theme of a health inequalities gap and she recognised the importance in rethinking how this could be tackled.

Mr Williamson agreed that the report had a good dynamic particularly in terms of crystallising the challenges and practicalities that lay ahead. He made some suggestions in respect of planned care and the provision of specialist care and welcomed the opportunity to explore these further with Dr Armstrong at the NHS Board's away day sessions in January 2013.

DECIDED

That the Clinical Services Fit for the Future: Case for Change be approved **Medical Director**

108. WAITING TIMES AND ACCESS TARGETS

A report of the Chief Operating Officer [Board Paper No 12/56] asked the NHS Board to note progress against the national targets as at the end of October 2012.

Ms 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 week's referral to treatment (RRT) and the waiting times for various specific treatments including accident and emergency, cancer, chest pain and stroke. She also highlighted the delayed discharge figures across NHSGGC.

NOTED

109. FINANCIAL MONITORING REPORT FOR THE 7 MONTH PERIOD TO 31 OCTOBER 2012

A report of the Director of Finance [Board Paper No. 12/57] asked the NHS Board to note the financial performance for the first seven months of the financial year

Mr James explained that the NHS Board was currently reporting an expenditure outturn of £0.4m in excess of its budget for the first seven 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. At this stage of the year, overall assessment was that, at 31 August 2012, the NHS Board was running £1m behind its year to date cost savings target although this was being offset by additional non recoverable savings against other budgets. Achieving the NHS Board's overall saving targets of £59m for 2012/13 remained a key factor in determining the Board's ability to achieve a breakeven outturn for the year.

In response to a question from Councillor Rooney, Mr Calderwood clarified that NHS Boards in Scotland could not carry capital forward year on year unlike local authorities who could. Although this created challenges, the NHS Board was constrained by the rules that applied to the health service in Scotland.

Mr Finnie sought clarification on the wording of the report in relation to off-setting additional in-year expenditure and Mr James advised that he would review the wording of this section for future reports in order to better describe the ongoing process. **Director of Finance**

NOTED

110. QUARTERLY REPORT ON COMPLAINTS – 1 JULY – 30 SEPTEMBER 2012

A report of the Nurse Director, Chief Operating Officer (Acute Services) and Director of Glasgow City CHP [Board Paper No 12/58] asked the NHS Board to note the quarterly report on NHS complaints received in NHS Greater Glasgow and Clyde for the period 1 July 2012 to 30 September 2012.

Ms Crocket advised that the report provided a commentary with statistics on complaints handling within NHSGGC for the period 1 July 2012 to 30 September 2012. It looked at complaints received and handled at the Local Resolution stage and by the Scottish Public Services Ombudsman and identified areas of service improvements and ongoing developments.

Ms Crocket led the NHS Board through the number of complaints received and completed in the quarter. In terms of performance, 77% of all complaints had been responded to within 20 working days.

Mr Williamson welcomed the new format of the report particularly the Appendix highlighting service improvements as a result of complaints completed in the quarter.

This highlighted the vast range of improvements made across the service both in acute services and partnerships.

NOTED

111. 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. 12/59] 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 five 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**

112. AREA CLINICAL FORUM MINUTES: 4 OCTOBER 2012

The Minutes of the Area Clinical Forum meeting held on 4 October 2012 [ACF(M)12/05] were noted.

NOTED

113. AUDIT COMMITTEE MINUTES: 9 OCTOBER 2012

The Minutes of the Audit Committee meeting held on 9 October 2012 [A(M)12/05] were noted.

NOTED

114. PHARMACY PRACTICES COMMITTEE MINUTES: 23 OCTOBER 2012

The Minutes of the Pharmacy Practices Committee meeting held on 23 October 2012 [PPC(M)12/05] was noted.

NOTED

115. QUALITY AND PERFORMANCE COMMITTEE MINUTES: 20 NOVEMBER 2012

The Minutes of the Quality and Performance Committee meeting held on 20 November [QPC(M)12/06] were noted.

NOTED

The meeting ended at 12.30pm