Trust Board

Minutes of the Trust Board meeting held in public on Thursday 3 May 2012 at 10 am in the Postgraduate Centre, the John Radcliffe Hospital.

Present

Dame Fiona Caldicott FC Chairman
Professor Edward Baker TB Medical Director
Professor Sir John Bell JB Non-executive Director
Mr Paul Brennan PB Director of Clinical Services
Mr Alisdair Cameron AC Non-executive Director
Ms Sue Donaldson SD Director of Workforce
Mr Chris Goard CG Non-executive Director
Mr Mark Mansfield MM Director of Finance and Procurement
Professor David Mant OBE DM Associate Non-executive Director
Sir Jonathan Michael JM Chief Executive
Mr Geoff Salt GS Non-executive Director
Mr Andrew Stevens AS Director of Planning and Information
Mr Mark Trumper MT Director of Development and the Estates
Mrs Elaine Strachan–Hall ESH Chief Nurse
Mrs Anne Tutt AT Non-executive Director
Ms Eileen Walsh EW Director of Assurance
Mr Peter Ward PW Non-executive Director

In attendance

Mrs Judith Lawton JL Interim Company Secretary (minutes)
Sarah Ann Moore KPMG Representative for Board Observation

The Chairman welcomed members of the public and Sarah Ann Moore, representative from KPMG.

Declarations – there were no declarations of interests.

TB35/12 Minutes of the meeting held on 1 March 2011

The minutes of the meeting were approved and signed as a correct record subject to an amendment on page 3. TB 20/12 Quality Report 2nd para, 1st sentence to read: ‘The new national outcome measure, the SHIMI, had not shown any change …’

TB36/12 Action Log

The action log was reviewed. It was noted that a number of actions had been included on the agenda.

TB37/12 Matters arising from the Minutes

Electronic Patient Record (EPR) update

The Director of Planning and Information confirmed that the implementation of the EPR system had been a significant technical achievement. The new system had taken some time to bed in but planning was underway for the next phase of the project which would involve roll out over the next year of the clinical functions of the
system. He indicated that the PAS sub group was identifying any issues and making sure training was aligned to the new system, and groups were also looking at A&E and Maternity.

The Director of Planning and Information stated that a process was in place to ensure any emerging issues were dealt with. Dame Fiona Caldicott requested the timeline for the realisation of planned business benefits, and timetable for clinical rollout, to be presented to July Board.

It was **resolved** to note the update

**Action:** (AS)  
*Document on the realisation of planned business benefits and timetable for clinical roll out to be presented to the July Board*

**TB 38/12 Chairman’s Business**

Dame Fiona Caldicott reported that the Chief Executive had been invited to become Trustee of the Kings Fund.

**Action:** (JL)  
*Chief Executive’s new interest to be recorded in the register*

**TB 39/12 Chief Executive’s report**

The Chief Executive, in presenting his report confirmed that a Court of Appeal had found the Safe and Sustainable process for the public consultation on the future of children’s congenital cardiac services to be fair, lawful and proper. He stated the Trust’s collaborative working with Southampton University Hospitals NHS Trust, one of the possible centres being considered to provide surgery for children with congenital heart disease, was working effectively but was an interim arrangement until the final decision was known. The consultation responses would now be carefully considered and a final decision was expected to be made in July 2012.

The Chief Executive reported the Health and Social Care Bill had been approved by the House of Lords and given Royal Assent to become the Health and Social Care Act (2012). The Trust would be working with its partners across Oxford and wide afar on its implementation with the Oxford Clinical Commissioning Group.

The Chief Executive reported that the first patients had attended the new renal dialysis unit at the Horton General Hospital on Monday 23 April.

Mrs Anne Tutt enquired about the specialist funding for urological surgery at Oxford University Hospital NHS Trust (OUH) and whether the funding received for renal auto-transplantation had any implications for the Trust. She was informed that a small number of funds were available for this form of care through the specialist commissioning arrangement and that the Trust would be fully covered with costs.

It was **resolved** to receive and note the report
TB 40/12  Quality Report

The report updating on the quality of care drawn from variety of clinical governance and nursing indicators was presented to the Board.

The Chief Nurse discussed with the Board the quality walkrounds and inspection visits activity and emerging themes and findings. The Chief Nurse stated that whilst the methodology and purpose of the walkrounds and inspections differed there was potential to cause confusion when the timing of the visits coincided, which she stated would be addressed in future scheduling. Non executive directors were pleased that both programmes had been well received and acknowledged that these were important components of the Trust assurance and compliance mechanisms. Mr Geoff Salt commented that it was important for the June Quality Committee to see the refreshed programme before the re-launch of the programme at end of June.

Mr Chris Goard referred to the patient experience data in the report and stated that it would be useful to have a good understanding of the issues and actions for improvement. Non executive directors noted the complaints received as a consequence of delays caused by the implementation of Electronic Patient Record.

The Board noted the rise in complaints and the link to cancelled operations. The Medical Director reported that the Trust had a lower than average rate of complaints than other Trusts and emphasised the long term plan was for more patient feedback as a mechanism for monitoring a range of activities across the Trust to ensure that improvements were realised.

The Director of Clinical Services stated that the Trust had taken over repatriation was now exploring how other hospitals managed this process to see what learning could be realised.

The Medical Director reported that there had been one serious incident requiring investigation (SIRI) and one never event in March 2012 and that all SIRIs were investigated in accordance with the Trust’s incident reporting and investigation policy. He stated that the profile of the WHO Surgical Safety Checklist and other safety critical standard operating procedures had increased over recent months. With route cause analysis (RCA) a key component to incident investigation, two lead investigators courses run by the National Patient Safety Agency on RCA training had been organised for Trust key staff.

The Medical Director stated that work was underway to introduce the electronic incident reporting system which should ensure that incidents were submitted to the NRLS in a more timely way. Currently 50% of incidents were submitted in more than 60 days after the incident occurred but the introduction of the electronic system could mean an increase in reporting levels.

The Board was informed that hospital acquired infections were well below target and it was acknowledged that this was a very good achievement for the Trust this year.

It was resolved to receive and note the report.
TB 41/12  Relocation of Head and Neck Services

The Chief Executive reported that the Board in July 2011 had agreed to suspend the transfer of Head and Neck Services to the Churchill Hospital for the following key reasons

- available theatre capacity at the Churchill Hospital was insufficient to cope with the additional surgical activity required to deliver the Head and Neck service.
- Critical Care was operating at full capacity due to the expansion of transplant and complex cancer surgery and could not accommodate the additional complex surgical activity associated with the Head and Neck service.
- out of hours services at the Churchill Hospital could not manage the additional activity and specifically handle the complex airway conditions associated with these patients.
- the additional revenue consequences of transferring the service to the Churchill Hospital were in excess of £1.5m and this was not sustainable in the current financial climate.

In addition concerns had been expressed about the clinical gain that would be derived from the relocation of this service given the excellent outcomes achieved by the Team operating from the John Radcliffe Hospital.

The Chief Executive reported that the Board had subsequently agreed to consider three options for the Services as part of a review into the Neuroscience and Specialist Surgery Divisions existing plan to move the Head and Neck Cancer Services from the John Radcliffe Hospital to the Churchill Hospital.

The Board discussed the various aspects of the review and considered the three options and financial implications as outlined in the paper. The Chief Executive reported that consultation with stakeholders, staff, public and service users had been undertaken on the three options. Four formal consultation and engagement sessions had been arranged and in addition, the Director of Clinical Services and Director of Planning and Information had responded to requests for individual meetings or attendance at patient and user group meetings. Staff, stakeholders, patients and the public had also been invited to provide views via a template questionnaire. The Chief Executive stated that the contribution by these groups had been extremely positive and delivered in a very professional and constructive manner. There had been an overwhelming view expressed by all of those involved in the engagement of complete support for the original proposal to relocate the service to the Churchill Hospital.

The Board was informed that the major constraints to the relocation of the Head and Neck Cancer Services to the Churchill Hospital relating to theatre and critical care capacity and the depth of the out of hours service to accommodate the complex airway patients remained and were a barrier to the service transfer. The Director of Clinical Services indicated that two options had been developed to address the capacity issues as an interim solution.
Mr Chris Goard, referring the population to be served (in access of five million) asked whether the Trust had the facility to manage this particular volume. The Director of Clinical Services stated that the Trust had the capacity to deliver the current service and service transfer and he was confident that the solution the Trust would bring forward would address that.

It was highlighted that one of the proposed recommendations was for the Director of Clinical Services to consult on options for service reconfiguration that would strengthen strategic, research and environmental issues associated with the current configuration of services across the John Radcliffe and Churchill Hospital sites and to bring proposals to the Trust Board in October 2012.

The Chief Executive stated that the Cancer Service was only one of the specialist roles and that the Trust needed to look at all the services for the future. Peter Ward referred to paragraph 18.3 of the report and asked the Chief Executive to ensure that when the implementation plan was developed for some very clear objectives and pragmatic marking plan to be included.

The Director of Development and Estates commented that there needed to be some tension in the system to make people work differently, for example, it was known there were capacity issues around theatres. This Trust needed to be using this as an example to transform service delivery and to challenge the way the Trust works.

Mrs Anne Tutt felt the document was a very good paper and the recommendations provided a really good outcome. In being asked how divisions had been involved, the Director of Clinical Services reported that the recommendations had been debated with divisional directors to understand the challenges and the two divisions and University strongly supported the transfer and were committed to making it work.

The Board in considering the recommendations set out in the paper resolved:

- to **approve** the relocation of Head and Neck Cancer services to the Churchill Hospital. The Board is asked to note the views expressed by stakeholders as outlined in paragraphs 14 to 16; the clinical and research benefits articulated in paragraph 18 and the answers to the three specific issues on IOG compliance, transfer of additional activity and the confirmation of commissioner agreement to the revised tariff as detailed in paragraphs 19 and 20.

- to **agree** that the full transfer of the Head and Neck service cannot commence until the 1st November 2012 due to the requirement to undertake additional surgical activity at the Churchill Hospital in order for the Trust to comply with the revised national 18 week Referral to Treatment standard for the NHS. A phased approach to the earlier transfer of non-surgical activity to be the subject of consultation with stakeholders.

- to **agree** to confirm the actual date for the transfer of Head and Neck Cancer services at the Board meeting on 5th July, following completion the development planning referred to in paragraphs 21 to 23.
• to note that the Director of Clinical Services will bring forward proposals to create additional theatre and critical care capacity to the July 2012 Trust Board.

• to note that the Director of Clinical Services will bring forward proposals for enhancing the provision of out of hours services at the Churchill Hospital to the September 2012 Trust Board.

• to agree the Director of Clinical Services should consult on options for service reconfiguration that would strengthen strategic, research and environmental issues associated with the current configuration of services across the John Radcliffe and Churchill Hospital sites and bring proposals to the Trust Board in October 2012.

Dame Fiona Caldicott stated that she was very grateful for all the hard work and effort by everyone and for the good decisions made

Action: [PB]

• Confirmation of the actual date for the transfer of Head and Neck Cancer services to the July Board meeting following completion the development planning referred to in paragraphs 21 to 23;

• Director of Clinical Services to bring forward proposals to create additional theatre and critical care capacity to the July 2012 Trust Board;

• Director of Clinical Services to bring forward proposals for enhancing the provision of out of hours services at the Churchill Hospital to the September 2012 Trust Board;

• Director of Clinical Services to consult on options for service reconfiguration that will strengthen strategic, research and environmental issues associated with the current configuration of services across the John Radcliffe and Churchill Hospital sites, with proposals to the October Trust Board

TB 42/12 Progress report on the application for Foundation Trust status

The Director of Planning and Information presented the report and discussed the Trust’s progress with its Foundation Trust programme. The Director of Planning and Information stated that membership recruitment was underway and the Trust now had nearly 6,000 public and patient members and was working to prepare for public consultation on its proposed governance arrangements as a Foundation Trust. A draft consultation document be presented to the Board for approval in June and pre-consultation work was underway. He commented that public meetings were being arranged and the participation of Board members was invited.

Mr Geoff Salt indicated that the Cardiac Open Day and similar events was a really good opportunity to recruit members.

Dame Fiona Caldicott, expressed thanks on behalf of the Board, to the Communications Team for the hard work they were doing.

Mr Peter Ward asked how the Trust is managing risk on the HDD. The Director of Planning and Information stated that it was a big change and the Trust had to anticipate what the changes would be. The team were already taking this into account and some assumptions and activities would be decided. The Trust would
need to put in some very robust scenario planning and the Director of Finance and Procurement and his team was leading the work. Mr Peter Ward asked if this was working with Monitor. The Director of Planning and Information stated that the Trust would need to stick close to Monitor and use wider networks, for example those ahead of the Trust.

The Board was asked to approve the response to the SHA, as detailed in the report, following discussions on the implications of the new Single Operating Model for FT applications.

It was resolved to receive and note the report and action plan for Foundation Trust status and to approve the response to the SHA as detailed in paragraph 6 of the report.

**TB 43/12 Draft Annual Business Plan 2012/13**

The Director of Planning and Information outlined the background and purpose of the document. He reminded the Board that the strategy and associated objectives were currently being reviewed in conjunction with the development of the Trust’s Integrated Business Plan. He stated that the final content of the paper might change between this and the final version as a separate paper on the Opening Financial Plans for 2012/13 was being considered by the Board and SLA negotiations with commissioners was still ongoing. He indicated that the Annual Business Plan would be presented to the July Board after the reiteration of the Integrated Business Plan and Long Term Financial Model to ensure it was aligned with the strategy. The Board noted it would be considering and agreeing the key changes to the Trust’s Integrated Business Plan and Long Term Financial Model at its May strategy awayday.

Mr Alisdair Cameron pointed out that the Trust needed to start the financial year with a healthy contingency to cover unexpected eventualities as had been experienced last year. The Director of Planning and Information stated there had been issues around controls and activity in the previous year particularly in relation to demand management, as well as other performance causing problems with Trust work profiles. He indicated that very robust contingency plans would be in place for 2012/13 and the Integrated Business Plan and Long Term Financial Model was being used in this way. The Director of Workforce stated that much work had been undertaken on aligning directorate workforce plans with commissioning intentions and finances for the coming year. The mechanisms were there and a close eye was being kept on the position. Workforce reviews were coming up and would be reported to the July Board.

It was resolved to note the third draft Business Plan 2012/13 and that the final draft would be submitted to the July Board for approval after the reiteration of the IBP and LTFM.

**Action: AS/SD**

- Final Business Plan 2012/13 to be presented to the July Board
- Workforce review to be reported at the July Board
TB 44/12  Quarterly Workforce Report

The Director of Workforce presented her report in which she indicated that the sickness absence level during the final quarter was 3.4% and was 3.4% for 2011/2 against the Trust’s internal target of 3.25%. She stated that targeted intervention in directorates where absence was above the Trust target was continuing and that the Health and Wellbeing Group had recently reviewed sickness absence causes and patterns of referral to the Occupational Health Department to assess what further support should be provided to staff and managers. The provision of stress management training had been one of the early priorities identified and as such would be rolled out across the Trust shortly. Confirmation was given that the Health and Wellbeing Group had also been exploring how to roll out good practice and systems utilised within the Musculoskeletal and Rehabilitation Division (formerly NOC) where the twelve month rolling sickness absence was 3.1%.

The Director of Workforce highlighted the national target by the Department of Health for sickness absence to be below 3% by 2014, and that in this context the proposed target for 2012/13 was 3.2% then to 3% the following year. The Board agreed this was a challenging target for the Trust and further discussed with the Director of Workforce the steps being taken to manage down the increase of sickness levels in line with the Department of Health guidance and the support being provided to specific staff groups where sickness absence was above average.

Referring to staff turnover, the Board was advised that during the final quarter that turnover was up 12.8% from cir 10.5% at the ORH pre-merger but with the cir 100 MARS leavers and impact of staff from the NOC removed (moved to a different payroll provider as part of corporate restructuring) the underlying turnover at 31 March was cir 11%. The Director of Workforce reported that the proposed turnover target of 2012/13 is to remain at or around 11%. The Board noted that while some turnover was good for the Trust, excessively high levels of turnover were costly in terms of potential disruption to services during the recruitment process, especially when skills were in scarce supply and the recruitment process is protracted. Assurance was given that the Workforce Committee was currently reviewing the impact of high turnover in certain specialities (cardiac, theatres, and orthopaedics) and seeking how a strategic approach might help resolve the issue.

The Director of Workforce reported that the appraisal target was currently 80%, with the 20% differential to reflect staff not available/eligible for appraisal, such as those on maternity leave, long term sickness absence, and new starters. However, it was proposed in 2012/13 that the target should be set to 100% of eligible staff, with the adjustment more accurately reflecting the circumstances of each area. The Medical Director confirmed that the appraisal returns for consultant medical staff had been promising and was now at a high level with more returns expected over the coming weeks. The Board was advised that work on the new appraisal documentation to support revalidation was continuing and a business case would be presented to the Trust Management Executive shortly.
Confirmation was given that a comprehensive review of statutory and mandatory training had been completed, with the introduction of a competence based approach for the current financial year agreed with the Trust Management Executive. A new policy and framework had been approved following extensive benchmarking of best practice across the NHS.

Referring to staff engagement, the Director of Workforce reported that following the approval of the new Trust values in January 2012, work had continued on putting the Trust’s values into action through its policies, practices and processes. Whilst part of this work had included identifying behaviours that support the Trust values in delivering compassionate excellence, the need for the Trust to continue to talk about its values and what this means for the organisation as a whole was recognised and support was given to the Listening into Action Programme.

Confirmation was given that divisions had been working on their workforce plans over the past months in order to align workforce and commissioning intentions and finances for the current financial year and submissions would be reviewed in May and a Trust wide overview provided to the June Board. Work was also continuing on the Trust’s workforce strategy in the application to become a Foundation Trust, an outline of which would be presented to the Trust Board at the forthcoming Board strategy away-day in May.

The Chairman stated that it was imperative to ensure that workforce targets and plans were agreed as a matter of urgency given the importance of these to the Trust’s agenda and indicated for future these should be agreed earlier in the financial year.

The Director of Workforce, when asked when the Board could see a reward and recognition scheme up and running, reported that an outline framework would be finalised by the end of June, and this would be presented at the July Board meeting.

In response to a question on what steps the Trust was taking on the anticipated industrial action linked to the ongoing dispute about changes to NHS pensions, the Director of Workforce reported the Trust had received formal notification of strike action on the 10 May but, following discussion with local union representatives, no major issues were expected. However, steps had been taken to ensure that contingency plans were in place.

It was resolved to receive and note the report.

Action: [SD]
- Outline of Trust Workforce Strategy and workforce plans to be presented to the Board Strategy away day 16/17 May
- Workforce targets to be finalised and communicated effectively across the Trust by end of May
• Reward and Recognition Scheme framework to be presented to the July Board meeting

TB 45/12  Operational Performance: Month 12

The Director of Clinical Services outlined that the document continued to be provided on a restricted basis as the teams work to clean up the data following the EPR transfer. He reported that all performance figures in the report had been validated and reflected actual performance with the exception of the 4 hour standard. He indicated that the 4 hour monthly figure was derived from the year to date position achieved prior to the EPR implementation.

The Board noted that C-diff and MRSA performance standards had been achieved for 2011/12, Cancer and 18 week RTT performance remained on track with all performance standards achieved in month with the exception of the surgical subsequent treatment standards. However, the Board was asked to note that this was a provisional figure and subject to further validation.

The Director of Clinical Services reported that delayed transfers of care remained the major concern for the organisation but steps were being taken to address the matter. The Director of Workforce stated that it was recognised that excessively high levels of staff turnover were costly in terms of potential disruption to services and the Workforce Committee had been reviewing the impact of high turnover in certain areas. Targeted intervention in directorates where absence was above the Trust target was continuing.

The Board was informed that the number of non medical staff appraisals completed in the rolling 12 month period ending 31 December 2011 was 74%, according to local records held. Current indications were that this had been maintained in the final quarter and the position would be confirmed as part of the quarterly performance review process.

The Director of Clinical Services commented that the Board would receive a report on CQUINs and IPR implementation in June.

It was resolved to receive and note the report.

Action: [PB]

Report on CQUINs and IPR implementation to the Board in June

TB 46/12  Financial Performance: Month 12

The Director Finance and Performance reported that the Trust had achieved its target surplus for the year and had, therefore, met its financial duty to breakeven. The Trust had under spent against its capital resource limit for the year by £2.4m and had also met its financial duty not to overshoot this target. The Trust had delivered 98% of its total savings for the year.

Mr Alisdair Cameron noted that the Trust was £2m short for Berkshire. The Director of Finance and Procurement indicated that the commissioning income had exceeded the plan as the result of over-performance against initial PCT contracts. He stated
that the majority of the predicted income for the Trust came from contracts with commissioners. The Director of Finance and Procurement reported that the Trust had held lengthy discussions with Berkshire. There had been some underlying issues and they now had a very clear view on patient flows from the PCT.

The Director of Finance and Procurement discussed the analysis of the savings programme for 2011/12 with the Board and confirmed that the Trust had delivered £57.2m in savings year to-date which represented 98% of the overall target for the year.

The Director of Finance and Procurement stated that it was imperative to set a good cost improvement plan which would be monitored carefully to ensure the plan was delivered. It was noted that the Trust had signed up in its cost improvement plan for theatre utilisation and that this needed to be in the upper quartile. There was clearly an issue around theatre utilisation. Dame Fiona Caldicott asked for the Chief Executive’s paper to be circulated to Board members.

The Director of Finance and Procurement was asked whether the NICU business case had been factored in and indicated that the Trust had received the money as additional capital income. Following extensive discussions with the SHA had spent it on equipment.

Mr John Bell stated that the Trust needed to consider reconfiguring some of its services and urged the Executive Team to work really hard to give some predictions on how these would work.

Mrs Anne Tutt commented that, subject to Audit, it was very good news for the Trust to have achieved its target and moved on from the past. The Director of Finance and Performance stated that the Trust had achieved its target within £6,000.

It was resolved to receive and note the position

**TB 47/12  Neonatal Intensive Care Unit Full Business Case**

The Director of Clinical Services explained that the full case as presented sought Trust Board approval to invest £3.079m capital in an extension to the Newborn Intensive Care Unit (NICU) at the John Radcliffe Hospital. The expansion was to effectively double the number of NICU cots to a total of 20 and increase the overall size of the unit from 41 to 53 cots with 3 additional SCBU/HDU cots. The JR NICU was the designated Newborn Intensive Care Unit for the Thames Valley region. £2.8 million funding was available from the Strategic Health Authority for this development. The Director of Clinical Services reported NHS South Central has confirmed their approval of the full business case.

The Director of Clinical Services discussed with the Board how the current NICU could not accommodate the increasing demand across Thames Valley (from both birth rate increase and increasing incidence and survival rates from premature births). He explained that the expansion would address this and allow for the repatriation of NICU activity currently going outside of the Network and into London.
The Director of Clinical Services discussed the revenue costs of the Unit and indicated that this would increase from the current level of £12.4m to 16.7m (£4.3m) when all the cots were open with a small increase in the positive contribution (surplus). He indicated that the increased income came from South Central Specialist Commissioners, whom together with the South Central Neonatal Network, had given their support for the case.

The Director of Clinical Services stated that the expansion provided enough cots to meet predicted Network demand, including all babies of less than 27 weeks gestation and repatriated babies from outside the Network, and would allow for limited further expansion of activity. He informed the Board that without this expansion this demand would be unmet and babies would be offered care outside the network, or not at all (given shortfalls in capacity in other areas).

The Director of Clinical Services reported that in March 2012, a £2.8m capital windfall was received from the Department of Health via NHS South of England to support this development. This was used to fund equipment and enabling works required to progress this development. He indicated that additional parental accommodation had been included following discussion at the Trust Management Executive during the approval of the Outline Business Case.

The Trust Board was asked to note a capital expenditure pre-commitment, provisionally assessed at £350k plus VAT, required to ensure commencement on site in early June 2012; to fund, for example, removal of trees within the site area prior to the nesting season, removal of hazardous materials from the site area and ordering of long lead-in time materials.

The Board discussed the staffing required for the project. It was highlighted that the changes to take place within the NICU would be led and managed by the clinician lead and matron and that the major changes to take place were the recruitment of additional staff for the additional cots, implementation of the full EPR system and clinical responsibility for maintaining safe and sustainable services during implementation. The Director of Clinical Services indicated that 70 staff in total were required and recruiting to medical staff may be easier than recruiting to nursing staff. To this end an outline workforce plan was in place linked to future implementation. Training and mentoring of staff would be rolled out as staff commenced employment.

It was resolved to approve the investment of £3.079m capital in an extension to the Newborn Intensive Care Unit (NICU) at the John Radcliffe Hospital.

TB 48/12 Remuneration and Appointments Committee Annual Report

The report outlining the activities of the Committee during 2011/12 was presented to the Board.

It was resolved to receive and note the report
TB 49/12 Report on consultant appointments and signing of documents

The report on consultant appointments and the signing of documents was received. The Board was particularly pleased to note the first appointment consultant midwife with effect 30 May 2012.

It was resolved to receive the report and note the consultant appointments and signing of documents.

TB 50/12 Minutes of the Quality Committee held on 20 March 2012

Mr Geoff Salt, presented the minutes and confirmed the key items discussed at the meeting held on 20 March 2011 as outlined in the report.

It was resolved to receive and note the report.

TB 51/12 Any other business

There was no other business.

TB 52/12 Date of the next meeting

The next meeting of the Board to be held in public will be on Thursday 5 July at 10.00 am.

The Board then considered and agreed the following motion:

“that representatives of the press and other members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) of the Public Bodies (Admissions to Meetings) Act 1960)”