Trust Board

Minutes of the Trust Board meeting held in public on Thursday 1 March 2012 at 10 am in the Postgraduate Centre, the John Radcliffe Hospital.

Present

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<th>Name</th>
<th>Title</th>
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<tr>
<td>Dame Fiona Caldicott</td>
<td>Chairman</td>
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<tr>
<td>Professor Edward Baker</td>
<td>Medical Director</td>
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<td>Mr Paul Brennan</td>
<td>Director of Clinical Services</td>
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<td>Mr Alisdair Cameron</td>
<td>Non-executive Director</td>
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<td>Ms Sue Donaldson</td>
<td>Director of Workforce</td>
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<td>Mr Chris Goard</td>
<td>Non-executive Director</td>
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<td>Mr Mark Mansfield</td>
<td>Director of Finance and Procurement</td>
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<td>Sir Jonathan Michael</td>
<td>Chief Executive</td>
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<td>Mr Geoff Salt</td>
<td>Non-executive Director</td>
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<td>Mr Andrew Stevens</td>
<td>Director of Planning and Information</td>
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<td>Mr Mark Trumper</td>
<td>Director of Development and the Estates</td>
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<td>Mrs Elaine Strachan–Hall</td>
<td>Chief Nurse</td>
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<td>Mrs Anne Tutt</td>
<td>Non-executive Director</td>
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<td>Ms Eileen Walsh</td>
<td>Director of Assurance</td>
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<td>Mr Peter Ward</td>
<td>Non-executive Director</td>
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Apologies

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<td>Professor Sir John Bell</td>
<td>Non-executive Director</td>
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<td>Professor David Mant OBE</td>
<td>Associate Non-executive Director</td>
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In attendance

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<td>Mrs Megan Turmezei</td>
<td>Associate Director of Governance (minutes)</td>
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The Chairman welcomed members of the public and representatives from NHS South of England

Declarations – there were no declarations of interests.

TB 15/12 Minutes of the meeting held on 3 November 2011

The minutes of the meeting were approved and signed as a correct record subject to the correct title of Director of Workforce for Ms Donaldson.

TB 16/12 Action Log

The action log was reviewed and the completed actions noted. A number of actions had been included on the agenda.

TB 17/12 Matters arising from the Minutes

TB04/12 Chief Executive’s report - Mr Ward asked that future reports on EPR include specific updates on the realisation of planned business benefits.

TB05/12 Quality Report – Professor Baker reported that an update on NICE compliance, the dashboard and SIRIs would be taken to the next Quality Committee meeting following work done by the Clinical Governance Committee. In response to a question from Ms Walsh, Mrs Strachan–Hall reported that the impact of intentional
rounding, particularly within the Emergency Medicine, Ambulatory and Therapies Division, was being reviewed and evaluated to ensure that the approach presented opportunities for positive interactions with patients and their families. Mr Stevens commented that a recent safety walk round on D ward at the NOC had seen very positive steps being taken to address falls and pressure ulcers.

**TB 09/12 Operational performance report Month 8** – in response to a question from Mrs Tutt, Mr Brennan reported that although the plan had been to have recruited 32 staff and be supporting 35 patients by now, recruitment problems had resulted in only 20 patients being in the system. Recruitment was also impacting on Social Services provision and hence four patients remained with OUH support beyond the 14 days. Work was now being done to review the recruitment strategies and also to introduce the service at the Horton General.

**TB 18/12 Chairman’s Business**

There was no Chairman’s business.

**TB 19/12 Chief Executive’s report**

The report was considered and the following points noted:

- Dame Fiona was congratulated on her appointment to lead the review into the sharing of health information.
- The CQC had confirmed the JRH’s compliance with all outcomes following its revisit in November.
- The launch of the Major Trauma Network from April with the JRH being designated as a major trauma centre – a phased approach is being taken to implementation. The Board noted the agreement on the best practice tariffs, which supported the delivery of the complex trauma work and the business case. The Board noted the completion of the final requirements of the business case and agreed that this should proceed. Mr Cameron asked about the impact on resources; Mr Brennan confirmed the phased approach and the proposals around the agreement of triage protocols with the Ambulance Service. Additional ITU capacity would be put in place and additional anaesthetics and interventional radiology support. Audit data were being gathered in support of the implementation and the provision of the specialist nursing support. This audit would take between six and seven months to complete.
- Mr Cameron suggested that the position be reviewed in three months and this was agreed. The Board noted that discussions were also being held with other providers about the potential for additional major trauma work coming to Oxford. Mr Mansfield confirmed the complex nature of the costings and the analysis needed; the position would be closely monitored. Ms Walsh said that the risks were being assessed, particularly in relation to the ambulance input. The Divisions were including risks within their Divisional Risk Registers so that these could be closely monitored through to the Trust Management Executive.
• The Board noted the plans being developed for an Academic Health Partnership across Oxfordshire and further proposals would be brought to the Board in due course. In response to Mr Ward, Sir Jonathan said that the partnership would complement individual organisations’ existing bilateral agreements and was intended to support collaborative activities across a range of areas. A report would be brought to a future Board meeting on the developing relationship between the Trust and the University.

JM

• The Board noted that certain key pieces of information remained outstanding in relation to the head and neck services. As a result, the discussion on the options for the services would be considered at the May meeting of the Board.

PB

• Mr Salt commented on the Patient event to be held on 12 March and hoped that this would be a positive occasion. Recruitment activities for FT members were now underway. The intention was to have recruited 7,000 members (4,500 members were already in place) by the time elections to the Governors’ Council were required.

• Sir Jonathan reported on an additional item: the Department of Health had just announced the award of NIHR funding to support clinical research for experimental medicine following a joint bid from the BRC and Oxford Health. The award was of £4m over five years and exemplified the success of the partnerships being developed.

TB 20/12 Quality Report

Professor Baker introduced the report which was in a state of development and not yet in its final form. An increasing focus was being placed on outcomes benchmarking. The dashboard was being developed. The Board noted that the East Midlands Observatory included 104 measures in total although only a small number were being included. It should be noted that these were historic data and hence not performance measures although it was useful to check that outliers as shown had been dealt with.

The new national outcome measure, the SHMI, had not should any change and remained within expected limits for the Trust. However, Professor Baker stressed the intention to reduce this over time. It covered 108 diagnostic groups and the report gave information on the current position. Clinical services were now being asked to review all outliers and to describe the actions they were taking to address issues.

Professor Baker highlighted the never event that had occurred in January and said that a full report would be provided to the Quality Committee. In addition, a full retrospective report on NICE compliance would be provided to the Committee and prospective audits were being put in place.

A detailed report on the walk rounds was in preparation for the Quality Committee. Further focus was being placed on the patient experience using the 15 step challenge. The Trust will be working with the SHA to take this forward.
The Board noted the first quality and risk profile for the OUH, but the discrepancy in the weighting of data (both the ORH and the NOC were been treated on equal terms) was the subject of continued discussion with the CQC, so that a more accurate position could be reflected in the profile. In response to a question from Mr Ward, Ms Walsh assured the Board that there were no issues in relation to data and its quality as provided to the CQC. The issues rather related to the CQC’s capacity to analyse and weight the data appropriately. This was the subject of long and ongoing discussions with the CQC which would be taken to resolution by Ms Walsh although the CQC had yet to commit to a timetable. A full analysis of the position would be brought to the Quality Committee for its review and to ensure that the actual position for the OUH was made clear.

The Board noted the actions underway in relation to antimicrobial prescribing.

Mrs Strachan–Hall commented on the removal of the individual divisional safe care boxes from the appendices and the further work being done to develop these metrics and to integrate these. The quality and safety of care was stable and any areas of concern were being followed up within the Divisions and through the reports to the Clinical Governance Committee.

The Board noted the rise in complaints and the link to the communications issues arising as part of the EPR implementation.

Mr Salt commented on the improvements in the reporting which he welcomed. He was particularly pleased to see the increased focus on benchmarking and outcomes and welcomed the opportunity that the Quality Committee would have to review these areas in more detail. Professor Baker said that further information would be provided on the Observatory to the Quality Committee, particularly in terms of interpreting outliers and their impact.

Mr Goard also expressed his thanks for the improved report and the increasing helpfulness of the report. He asked that the Divisions ensure that issues of communication within clinical teams were addressed and he would be anxious to have assurance on this. It was noted that the Clinical Governance Committee would follow up on these issues. Ms Walsh highlighted the work being done to look at information and assurance and the content of papers being prepared for review within the OUH’s governance arrangements. There was a need for different reports to meet different requirements; reports to the Clinical Governance Committee would be different from those considered by the Quality Committee for assurance purposes. The nature of reports and the transmission of information to the Board were currently being developed. Dame Fiona suggested that it would be helpful to review data sources from elsewhere.

Mr Cameron asked whether the OUH had sufficient analytical resource and capability to review all data items and identify the actions required. Professor Baker agreed that the plethora of data did test capacity and it would be very important to prioritise activities accordingly.
Mrs Tutt commented on the improved action plans included within the Appendices. She also asked that she receive copies of the Quality Committee papers. Dame Fiona said that all Board members could receive these and the papers for all other committees if they wished. Ms Donaldson commented on the work being done to triangulate sources of information and to integrate reporting.

Dame Fiona welcomed the improved report and noted the comments made by members and the further reports to be taken to the Quality Committee.

The Board received the Quality Report.

TB 21/12 Medical revalidation – update on organisational readiness

Professor Baker introduced the document which updated members on the revalidation process within the OUH. 1100 doctors would require revalidation, including honorary contract holders. The late receipt of guidance had caused some delays and outstanding guidance was awaited. However, progress across the organisation was good. Appraisal was the key to revalidation and the move to the new process would be important although currently the old system remained in use pending final guidance.

Professor Baker raised the matter of data handling and the need for IT system support. Resources would be required in the coming year to provide this support the design of which would be finalised once all relevant guidance had been received. The aim would be to integrate the system into IT solutions for workforce and governance.

Sir Jonathan said that there were two areas of potential risk: firstly doctors in training who were the responsibility of the deanery and agency/locum medical staff who were the responsibility of the employing agency. However, further guidance was expected on clinical academics although it was clear that the OUH will be the designated body for the processes for this group of staff.

Mr Goard asked whether there was sufficient resource for the process to be delivered. The availability of appraisers would be key and additional trained appraisers would be needed above the current level of 140. The SHA was supporting the process of training, and work would also be needed to ensure that the right quality assurance processes were in place and that appraisers were also appraised. The scheduling of medical time to accommodate training and appraisal sessions would also be critical. Mr Cameron commented on the nature of the compliance task although both opportunities and risks were associated. Positive outcomes were required for medical staff but in addition, it would be important to gain benefits in terms of performance. Professor Baker highlighted the two aspects of this: the role and duties of the employer and the needs and requirements of the GMC. The dual role would need managing and whilst it was relatively clear in relation to the OUH’s own staff, the role in relation to honorary contract holders was less clear. It was noted that appraisal and revalidation would be a key item for discussion at the recently established Joint Personnel Group with the University. Mrs Strachan–Hall suggested that the framework might provide a model for all healthcare professionals.
and that it would be sensible for any IT solution to cover all staff groups. This view was supported.

Professor Baker commented on the new approach for the choice of appraiser; this choice would be made by the clinical manager and appraisers would also be rotated to ensure independence. Dame Fiona suggested that a paper outlining the links to and relationships between appraisal and performance management should be brought to a future Board meeting. Ms Donaldson said that this work was underway and she would bring a report to a future meeting of the Board.

The Board received the report, noting the progress and the current position. It would receive further reports on progress through the process.

**TB 22/12 Update on the development of the Trust’s Quality Assurance System**

Ms Walsh introduced the report and highlighted the importance of strengthening the systems and processes to support the delivery of the Trust’s strategic objectives and the achievement of FT status. The systems planned would support the Assurance Strategy drawing on robust information and verifiable evidence.

A significant amount had been achieved and the phased implementation of the software in support was now underway. In particular, the work would support the development of the Board Assurance Framework and risk registers, with additional activities aimed at embedding and educating across the Trust moving forward.

The work would be challenging and help drive a change in culture, systems and processes and result in new ways of working, sourcing evidence and strengthening the reports. The system (HealthAssure) will also attribute values to information and hence contribute to the assessment of compliance and provision of assurance.

Mrs Tutt asked whether sufficient resource was available to support this and the Board noted the current recruitment to three senior posts: the Head of Assurance, the Head of Regulation and Accreditation and the Head of Corporate Governance (Company Secretary). These would be specialist technical roles working in support of the Board, the divisions and the services. The capacity was now being built alongside the system development.

Mr Trumper said that the estates directorate was acting as a test bed and that OUH’s sub-contractors would also be engaged in the work as their compliance with OUH’s policies, systems and processes would be key. The PFI providers would also be involved.

Professor Baker gave his strong support to the development which would provide assurance through the active collection of information with positive impacts on front line services. The systems would support the regulatory framework, including CQC and NHSLA and with potential changes in regulation, it would be invaluable. Ms Walsh said that the system would be future proofed and able to cope with changes. It would support the BAF, CQC, Risk Registers and NHSLA. Its key characteristic was the ability for information to be sourced once but used for a wide range of assurance and management purposes.
Mr Salt confirmed his support and commented on the excellent presentation on the system given to the Quality Committee in September. He noted that the updated risk registers and Board Assurance Framework were to be presented to the next Quality Committee.

The Board strongly welcomed the proposals and progress to date and agreed to support the implementation of “HealthAssure” and the revised processes across the Trust as outlined.

TB 23/12  Equality Delivery System

Mrs Strachan-Hall introduced the paper and the use of the toolkit to deliver the goals and delivery of the Act. The Trust had already published information and its objectives would be refined annually. Data capture would be crucial in delivering the goals although the sensitivities were noted. The potential of both the electronic staff record and the electronic patient record were noted.

In discussion on the EDS goals in section 9, Mr Mansfield wondered if the goal of 95% (9.3) was perhaps too low. It was agreed that there would be benefit in refining the goals to differentiate more between staff and patients and ensure that despite the difficulties, as much information as possible was available on disabilities. Professor Baker welcomed the goals and the importance of linking them to values and culture. Mrs Strachan-Hall supported this view and agreed to take forward a reworking of the points in relation to 9.3 and 9.4. She commented that the grading panels would also review the goals. It was agreed that linkage to the OUH’s values from the start would be crucial and these should be used as a starting point.

Mr Stevens commented on the thought that needed to be given to collection of sensitive data from patients. Dame Fiona agreed that this needed careful consideration especially in the context of seeking as broad a membership for the Trust as possible.

Mr Cameron agreed that this was a difficult area; the data were important but it was not possible to insist that staff or patients provided the information. Sir Jonathan agreed that it was important to recognise sensitivities but also that it would be important to try and find ways to elicit information. Often, information on learning disabilities was very hard to obtain.

It was noted that work was also be done to establish good solutions and practice from elsewhere. Mrs Strachan-Hall was on the national council and work was to be done with hard to reach groups.

Mr Salt agreed that further work needed to be done and asked that this also be linked to the Values and the preparation of the Quality Account.

The Board endorsed the continued use of the Equality Delivery System as a framework to progress compliance with the Equality Act 2010 and approved the proposed equality and diversity objectives (subject to the review outlined above). The Board agreed that progress against the objectives should be monitored by the Clinical Governance and Workforce Committees of the Trust Management Executive and reported to the Board.
TB 24/12  Progress report on the application for Foundation Trust status

Mr Stevens presented the report and members noted that all current activities relating to assurance, quality and performance, were intended to support the achievement of FT but primarily to deliver improvements in the performance of the OUH as a whole.

Mr Stevens confirmed that progress was in line with requirements of the Tripartite Framework Agreement. An executive to executive meeting had been held with NHS South of England on 27 February. A number of specific activities had now been started including the Board quality and finance assessments and members recruitment. Information would be made available to Board members who might wish to attend such activities.

The Board received the report and noted the progress to date.

TB 25/12  Progress report on the deployment of the Electronic Patient Record

Mr Stevens presented the report highlighting issues in relation to patient safety, patient experience and data quality. Technically, the implementation had been a success and a fully planned feedback and assessment system had been in place since the start. The implementation had been managed using the model of the Major Incident Plan.

A particular issue had been the underestimation of the impact on the Patient Contact Centre, which had resulted in delays in responding to patient calls. This had resulted in a significant increase in complaints. Actions to rectify the problems had been taken and the performance levels of the Centre had now risen back to their pre-implementation levels. It was hoped that the complaints would now be reducing. Particular impacts had also been felt in high volume areas, e.g. ophthalmology clinics.

Some data issues remained although much was being done to resolve these and agreements had been reached in relation to reporting regimes. There had been no disruption to invoicing and 18 week reporting had been restored after just a month’s gap.

Within the emergency department some processes were taking longer than had been expected but discussions were continuing and plans were being developed to ensure resolution by the end of March. Safety nets for data capture were in place however.

The next steps involved consolidation, service reviews and the roll out and review of benefits. The plans were in place but would be reviewed to ensure alignment with strategic objectives. This plan would be brought to the Board in summary in May.

With respect to issues with the emergency department, the slight increase in time taken to complete the clinical record, the fundamental part of the EPR, was having some impact on the workflows. However, changes were being planned and additional refresher training on the system was being provided.
Mr Ward commented on the messages coming from physiotherapy staff at the Horton about problems in the system. Mr Stevens confirmed that there had been a specific issue in relations to Allied Health professions clinics but that was being actively dealt with by the build team. 600 of the 800 build issues (some extremely minor) had now been resolved and there was confidence about the completion of build issues. There had been no Horton specific EPR issues.

The Board noted that the next phase involved clinical roll out and respiratory medicine would be taking this forward as an exemplar. The experience of the NOC would be particularly valuable in the next phase.

Mr Salt commented on the importance of the project for the Board and that its delivery was credible for staff and patients. It was felt that the team were being realistic and that the process review will support credibility and set the platform for winning hearts and minds. Mr Salt said that he welcomed the open and honest approach to the problems.

The Board received the report, noting future plans and welcoming the progress to date.

The Board also wished to record its thanks to all those involved in the implementation.

TB 26/12  Operational performance Month 10

The Board received the report noting specifically the issues in relation to the continuing high number of delayed transfers of care. These high numbers impacted significantly on the operational performance of the hospitals but more crucially impacted on the quality of care for patients whose discharge to more appropriate accommodation was being delayed.

However, Mr Brennan reported on the continuing work being done across the local health economy to resolve the issues. Sir Jonathan also reported on the work being done at the highest levels with the strongest commitment from all parties. Professor Baker said that the impact on patients was the most significant current quality issue not only within the OUH but across the system. The impact was most significant within the EMTA division although they continued to work extremely hard to reduce the impacts. Their efforts were recognised by the Board.

Dame Fiona looked forward to hearing more about the work aimed at reducing DTOC. Mr Salt said that it was essential to say that another winter like the one just passing could not be tolerated; work must be done to resolve the issues.

TB 27/12  Financial performance Month 10

Mr Mansfield spoke to his report and highlighted the risks to performance although work continued to ensure delivery of the financial plan. Mr Goard asked about the income analysis in relation to Milton Keynes shown in Chart 5. Mr Mansfield confirmed that efforts continued to secure planned income although changes in the configuration of PCT clusters and the former regions was now impacting on the OUH.
Mrs Tutt commented on the liquidity/cash management issues. Mr Mansfield agreed that reducing debtors would impact positively on liquidity and work continued to be done to the year end to reduce debtors. He referred to new controls in place for NHS Debtors. Mrs Tutt also asked about capital spend and whether any crucial schemes were being delayed. Mr Mansfield confirmed that the Trust Management Executive continued to review the capital programme to ensure that no critical schemes were delayed. BRC funds remained ring fenced. In response to a question from Mr Ward, it was confirmed that the capital funds included funds for IT systems, including those in support of assurance and revalidation. Proper treatment of PFI had been included in the last month’s accounts in relation to the changes to the categories of payments and the gearing of interest.

Recruitment controls would continue to be a challenge for the Trust and would remain an issue going into 2012/2013.

The Board noted (Table 7) that £45m of the CIP had been achieved although there had been significant variations in the delivery rates across all the schemes. Mr Mansfield stressed that CIPs were reviewed regularly but the approach had been to ensure flexibility of approach; 95% had been delivered. The CIP for the coming year was £50m and the bulk was now being identified by the Divisions; efforts were being made to ensure congruence with the strategic objectives. The SAFE methodology was to be adopted for CIPs to cover safety, and quality across all proposals. Corporate support was in place for this and to ensure linkages across programmes and with the risk agenda.

The Board welcomed this approach, and received the report noting the position and the risks.

TB 28/12 Opening Financial Plan 2012/2013

The Board then considered the paper which set out the Opening Financial Plan for 2012/2013 and made a number of recommendations with respect to it. The paper outlined the policies for setting the plan and objectives, highlighted risks remaining in the emerging position, outlined the capital programme for 2012/2013 and asked the Board to endorse the financial plan with effect from 1 April 2012. Mr Mansfield outlined the remaining issues to be resolved which included income and activity for both local and specialist commissioners; and budgets and internal arrangements which would be considered and finalised by TME on 24 March. A full paper on budgets and the plan would be brought to the Board on 5 April for approval.

Mr Cameron stressed the importance of delivering to financial plan from day 1 across all areas. Mr Mansfield confirmed he was relatively confident about the ability to manage throughout quarter 1 although it should be noted that the period contained a significant number of bank holidays which impacted on income. As a result the cost and spend profiles were being adjusted realistically. Mr Cameron asked also for information on the planned FTEs across the months and Mr Mansfield agreed to circulate this information.
Mr Goard asked about triage arrangements in relation to activity above agreed levels and noted that work continued to look at triage arrangements and applicability to other clinical services following the orthopaedic model. Mr Brennan stated that lessons were to be learned from the hub approach and discussions continued with the PCT on this.

Mrs Tutt raised the question of liquidity and the relationship with the Financial Risk Rating levels required by Monitor. Mr Mansfield confirmed that liquidity remained a challenge but much was being done to improve the position and as part of the application process and particularly to test financial readiness, a mock HDD (historical due diligence) was to be held shortly. In addition, the OUH was working with the SHA to prepare a business case for a working capital facility in advance. Mrs Tutt said that it would be important for the Trust to be able to demonstrate that it had done all that it could to improve the position.

Mr Salt suggested that the Board Development programme now underway should include specific sessions on a number of issues including liquidity, risks and to draw on best practice from the best performing FTs. Mr Mansfield agreed to take this forward.

Mr Ward commented that resolution of the DTOC issue would have a significant impact on the revenue position and asked whether capital plans (to be reviewed by the Strategic Planning Committee and TME in March) would allow developments needed to maintain services, to manage depreciation and to ‘lubricate’ operational change. It was agreed that this should be discussed further by the Board at a seminar.

The Board agreed:

a) To endorse the plan to set a target surplus of £7.4m, or 1% of planned turnover for the 2012/13 financial year;

b) To endorse the plan to include a contingency budget of 1% of planned turnover, within its 2012/13 budgets;

c) To endorse the overall approach of this methodology for setting the 2012/13 operational budgets;

d) To note the opening planned balance sheet positions for the Trust in 2012/13;

e) To note the opening planned cash flow position for the Trust in 2012/13;

f) To note the Trust’s financial risk ratings for 2012/13 as calculated from the opening plans for the year.

The Board then approved the opening financial plan for 2012/13 as set out in Appendices A to D, taking full account of the assumptions and level of risk identified within it, and agreed the next steps for approving the final financial plan once contracts with commissioners have been agreed.
TB 29/12 Declarations and Register of Interests 2011/2012

The Board considered the report on the declarations of interests and the register of interests. Mr Salt reported he had been appointed as a Trustee of the Oxford Kidney Unit Fund; this would be added to the Board’s Register of Interests and the whole report would be included in the Annual Report for 2011/2012. JM

The Board noted that work was continuing on the collation of interests, gifts and hospitality across the Trust, and the Divisions had been reminded of the importance of good governance practice in their areas.

TB 30/12 Report on consultant appointments and signing of documents

The Report on consultant appointments and the signing of documents was received by the Board. Mr Stevens said that the appointment to the paediatric consultant post was the last in the series of appointments made as part of Oxfordshire paediatric service development. In addition, the interventional radiology posts would support the Major Trauma Centre service.

TB 31/12 Minutes of the Quality Committee held on 15 December 2011

The minutes and key items discussed at the meeting held on 15 December 2011 were received as outlined in the report. It was noted that a programme of patient stories was being planned for meetings throughout the year. In addition, the next meeting would be considering the updated BAF and Risk Register. ESH

TB 32/12 Minutes of the Audit and Finance Committee held on 16 December 2012

Mr Cameron spoke to the minutes and highlighted the discussions on the provision of internal audit services, and the importance of delivering to overdue recommendations. The Audit and Finance Committee would also be considering the updated BAF and Risk Register at its next meeting. The Minutes of the meeting were received.

TB 33/12 Any other business

There was no other business.

TB 34/12 Date of the next meeting

The next meeting of the Board to be held in public will be on Thursday 3 May 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)”