Trust Board

Minutes of the Trust Board meeting held in public on 9 January 2013 at 9am in the George Pickering Postgraduate Centre, The John Radcliffe Hospital.

Present:	Dame Fiona Caldicott	FC	Chairman
	Sir Jonathan Michael	JM	Chief Executive
	Professor Sir John Bell	JB	Non-Executive Director
	Mr Alisdair Cameron	AC	Non-Executive Director
	Mr Chris Goard	CG	Non-Executive Director
	Mr Geoffrey Salt	GS	Non-Executive Director
	Mrs Anne Tutt	AT	Non-Executive Director
	Mr Peter Ward	PW	Non-Executive Director
	Professor David Mant OBE	DM	Associate Non-Executive Director
	Professor Edward Baker	EB	Medical Director
	Mr Paul Brennan	PB	Director of Clinical Services
	Mr Mark Mansfield	MM	Director of Finance & Procurement
	Ms Elaine Strachan-Hall	ESH	Chief Nurse
	Ms Sue Donaldson	SD	Director of Workforce
	Mr Andrew Stevens	AS	Director of Planning & Information
	Mr Mark Trumper	MT	Director of Development and the Estate
	Ms Eileen Walsh	EW	Director of Assurance
In attendance:	Ms Anne Dawson		NHS South of England
	Ms Jayne Turnbull		NHS South of England
	Mr Adewale Kadiri		Deputy Head of Corporate Governance (minutes)

The Chairman welcomed Board members and the SHA observers.

TB01/13 Apologies and declarations of interest

There were no apologies. The Non-Executive Directors and the Chairman indicated an interest in Item TB 19/13. No other declarations of interest were made.

TB02/13 Minutes of the meeting held on 1 November 2012

The minutes were approved and signed as a correct record, subject to the following amendments:

- Ms Walsh asked that the word “not” be removed from the first line at page 7, as the Trust does issue honorary contracts to non-consultants
- Mr Salt asked that the phrase “…of its choice.” Be added to the first sentence under (b) Quality Committee on page 12.

TB03/13 Matters arising from the minutes

There were no matters arising from the minutes.

TB04/13 Action log

Mr Cameron did not consider that the action on emergency planning had been completed as the update did not indicate whether steps had been taken to address the issue raised. Mr Brennan agreed to provide a fuller update.

Action (PB)

A clearer update is to be provided on what was being done on the issue of live exercises to test emergency preparedness

TB05/13 Chairman's Business

Dame Fiona did not report any Chairman's Business.

TB06/13 Chief Executive's Report

Sir Jonathan drew the Board's attention to the National Operating Framework, and explained that this was an evolving process, with some further guidance to emerge in the coming weeks. Mr Mansfield would be preparing a briefing on the guidance and its implications for the organisation, and this would be presented at the next meeting. He explained that this was a new process, being overseen by the National Commissioning Board for the first time. Dame Fiona expressed particular interest in the requirement within the guidance for the provision of better data.

Action (MM)

A detailed briefing on 'Everybody Counts: Planning for Patients 2013/14' is to be presented to the Board meeting in February.

Sir Jonathan provided an update on the Oxford Academic Health Science Network (AHSN). He stated that in February, representatives of each of the AHSNs would be attending panel interviews, but explained that this would not be a "pass or fail" process, as 15 AHSNs had already been identified across the country. The focus would be on ensuring that the networks are well enough developed to achieve accreditation. Authorisation would be agreed by the Commissioning Board in due course, and a more detailed report would be brought back to the Board at that stage.

Action (JM)

A detailed report on the Oxford AHSN is to be brought to a future meeting of the Board upon authorisation by the National Commissioning Board

Sir Jonathan informed the Board that the Trust's Integrated Business Plan had been published and was available on the Trust's intranet as well as its external website.

Dame Fiona informed the Board that Dr David Haslam, incoming Chairman of NICE, is a member of the review panel that she is leading on Information Governance.

Mr Salt raised a question about the new contractual duty of openness in all commissioning contracts. Mr Stevens explained that the Trust already makes all relevant information about its services, such as serious incidents requiring investigation (SIRIs), available to commissioners, but stated that the new contractual duty made this more structured, and introduced a duty to be open to patients. Professor Baker added that the Trust already had a Being Open policy, and commented that concerns expressed nationally about the contractual duty could mean that the duty would require some adjustment.

TB07/13 Quality Report

Professor Baker informed the Board of continuing improvements to the format of the report, including the introduction of more graphical displays. In terms of highlights, he reported that mortality rates as measured by the Hospital Standardised Mortality Ratios (HSMR) were within the expected range, and the year to date figure was just under 98%. The Summary Hospital-Level Mortality Indicator (SHMI) was due to be published later this month, and he did not expect any surprises.

The Hospital Guide published by Dr Foster in December 2012 had highlighted the issue of mortality rates for patients admitted at weekends, and work done following this finding had confirmed that such patients tended to be considerably more unwell than those admitted during the week. A review had been conducted of the level of out of hours cover at weekends, and Dr Foster had confirmed that the Trust provided the highest level of cover. Professor Baker acknowledged that the Trust needed to focus on increasing the availability of specialist services, such as endoscopy, at the weekend. He also suggested that the Trust needed to work with partners within the local health economy on care pathways at weekends.

Professor Baker informed the Board that as at the end of December 2012, all the delayed Medical Device Alerts (MDAs) had been closed. On incidents, he referred the Board to the chart showing the numbers reported since April 2012, and reminded members that the number of incidents was expected to rise with the introduction of Datix. He also suggested that the patterns would change, with falls and medication errors topping the list.

In relation to infection control, Professor Baker reported that the Trust was within its threshold for *Clostridium difficile* (C diff) and MRSA. He explained that the C diff target was particularly tight, and that the Trust was just below trajectory, as 7 cases

had been reported in November. A number of steps had been taken to address issues, including providing an urgent update of the relevant guidance and ensuring that this was followed by clinicians, as well as a strict testing regime. More work was also being done on surgical site infections, including the introduction of new protocols and practices in theatres. Professor Baker undertook to report more fully on this in March.

Action (EB)

Report on steps being taken to address surgical site infections to be presented to the Board meeting in March

Mrs Strachan-Hall presented the second part of the report. She provided the Board with an explanation of the patient safety thermometer, stating that on a specific day each month, every Trust is required to conduct a count of the total number of patients who had suffered one of four named “harms”. The Quality Committee had been provided with a comparison of “harm-free” care at Trusts within the Shelford Group, but they had concluded that the methodology was not sufficiently robust yet to enable useful comparisons. Mrs Strachan-Hall indicated that the level of “harm-free” care provided by the Trust was rising. She stated that in the next financial year, the focus would be on reducing pressure ulcers, as she anticipated that the CQUIN target in this area would be tough, and this had been agreed as a priority within the Quality Strategy. The Trust would be concentrating on heel ulcers particularly.

Mrs Strachan-Hall commented that not many patients choose to complain about their care, but that their concerns were often captured through other types of feedback. This feedback remained overwhelmingly positive, but was likely to change when the Friends and Family Test was rolled out, as the feedback would be sought after patients had left the care environment.

Mr Ward welcomed the contextual information provided on complaints, noting that in two of the divisions there had been increases in the numbers received, and he wanted to understand what had been done to address this. Mrs Strachan-Hall attributed these increases to the length of waiting times for appointments, and that a report on steps being taken to address this issue was to be taken to the Clinical Governance Committee. Mr Ward also questioned why so many of the boxes in the divisional quality dashboards had been greyed out. Mrs Strachan-Hall explained that in some cases, the information was not available because it was not collected by the division in question. She added that at present, the dashboards are created through a legacy system, but that in future, they would become part of the Integrated Performance Report with a more robust methodology and revised metrics. Ms Walsh spoke of the need to strengthen the reporting of the use of antimicrobials within the quality dashboards, and to better explain steps that were being taken to address

shortfalls. Mrs Strachan-Hall advised that extra time was being provided by two consultants who were leading on this issue at the John Radcliffe and Horton Hospitals. Some divisions were reporting very small numbers, and as such, there was a requirement to report performance in a more sophisticated way. There was some evidence that improvements in the prescribing of antibiotics had contributed to the drop in C diff rates.

Mrs Tutt enquired as to when a detailed analysis of the efficacy of the appointments system was due to take place. Mr Brennan explained that the work would be done in three stages:

- Mapping the level of internal and external demand against capacity
- Negotiations with the Clinical Commissioning Group about moving some activity into the community, and
- Generating new capacity.

He stated that the work would be starting during the following weekend and completed by the end of March. The outcomes would be considered by the Trust Management Executive and reported to the Finance and Performance Committee and then the Board.

Action (PB)

The Report on the analysis of the appointments system is to be presented to a future meeting of the Finance and Performance Committee at a date to be agreed and subsequently to the Board

Sir John questioned why feedback from the 'let us know your views' leaflets was still being analysed in light of the low numbers returned. In response to a question about the Mortality Focus Group, Professor Baker stated that this would be an important group in the long term, but that it was not yet in a position to report. On emergency readmissions within 28 days, he reported that as the Trust codes more patients than average to general medicine rather than to individual specialties this creates a perception of increased readmissions in medicine. The previous fortnight had been difficult, with focus on ensuring the availability of sufficient capacity to manage the extra demand.

Professor Mant commended the report's continued improvement. He made reference to deaths at weekends and commented that patients were being admitted for palliative care when they had previously indicated their preference to die at home. Professor Baker acknowledged the point and stated that there was a need to consider the suitability of end of life care as a whole.

Sir Jonathan gave an example from Surgery and Oncology of how the divisions were using data to drive improvement. Dame Fiona found this helpful, and encouraged other executive colleagues to bring any other examples they might be aware of to the Board's attention.

The Board resolved to **note** the contents of the report.

TB08/13 Reporting Patients' Stories

Mrs Strachan-Hall presented this discussion paper. She reminded the Board that the Quality Committee had been receiving patients' stories for some time, and explained that the purpose of presenting such stories to the Board was to ensure that the patient's voice was central to their deliberations. She had suggested a number of options following a review of what other Trusts were doing, and her recommendation was that the stories be made available to all Board members before their meetings.

The Board discussed how stories could be selected in such a way that there was a balance between those that were positive and negative about the Trust's services. Mrs Strachan-Hall was confident that there would be balance, and suggested the creation of a library of stories, from which a non-executive director could choose the one to be received at each meeting. There was some doubt as to whether the Board would have sufficient time to discuss the issues arising from a story, but it was agreed that the purpose of receiving the stories was to set the tone at the Board meeting rather than having the sort of detailed discussion that took place at the Quality Committee.

Mrs Strachan-Hall informed the Board that the Quality Committee would be discussing the selection issue again at their meeting in February. Mr Stevens suggested that the patient's story should cover the whole patient journey and not just the Trust's perspective.

Dame Fiona summarised the discussion and acknowledged that the Board was not yet in a position to decide on the methodology for receiving patients' stories at its meetings. She agreed that the Board could but should not replicate what the Quality Committee does, and she stated that the suggestion for Board members who did not routinely attend the Quality Committee to agree a time when they could hear the story to be considered by that Committee should be included in the review. She also suggested that advice be sought from other Trusts that had been receiving stories of this nature for some time. It was agreed that the issue be brought back to the March meeting of the Board via the Quality Committee.

Action (ESH)

A report setting out how patients' stories are to be selected and received at Board meetings is to be presented at the Quality Committee meeting in February and then the Board meeting in March

The Board resolved to **note** the report and its recommendations.

TB09/13 CQUIN and Quality Account progress and priorities

Professor Baker presented this paper, stating that a decision was required on a recommendation from the Quality Governance Framework. He informed the Board that the Trust was making good progress in meeting its CQUIN and quality priorities. The CQUIN on dementia screening was causing some difficulty, but the Trust was working with the PCT to focus on high risk areas. Learning would be rolled out across the organisation but this could not be done electronically. Professor Baker drew the Board's attention to the proposed quality priorities for 2012/13 for immediate inclusion in the Integrated Performance report. He advised that there was a hierarchy:

- 6 CQUINs would act as a gateway to access and would represent 2.5% of income, for example oesophageal Doppler monitoring and child in a chair
- 6 National CQUINs would account for 0.5% of income
- There would be local CQUINs as well, the value of which could be negotiated

Dame Fiona asked that these categories should be reflected when the report was next presented to the Board. Mr Trumper reminded the Board that this was a list of priorities for the commissioners but that it ought to be developed further in areas that were important to the Trust.

Sir Jonathan commented that some of the priorities did not appear to have outcomes. Sir John agreed and expressed the view in relation to dementia screening that it was not unreasonable to have a system that screened everyone over 75. Professor Baker agreed, but suggested that it would be challenging to implement this across the Trust on a paper based system. Mr Brennan indicated that there was already a system in place that checks screening, but it would not be able to check every patient over 75.

Action (EB)

A report including a list of CQUINs broken down by category and the amount of income that they represent is to be presented to the next Board meeting in February

The Board resolved to **note** the progress made with the CQUINs and to defer their consideration of the recommendations until their next meeting.

TB10/13 Quality Governance Framework re-assessment

Professor Baker presented this paper, reminding the Board that the Trust had self-assessed itself with a score of 4 against Monitor's Quality Governance Framework. RSM Tenon had reviewed this, and scored the Trust 4.5. An action plan was in place until March, but many of the actions have already been achieved, and he was confident that the Trust would be able to achieve a score of 3.5 and lower by the end of March.

Question 1a related to the launch of the Quality Strategy and its integration into the Trust's wider strategy. This was described as an area of strength, and Professor Baker advised that the implementation plan was well advanced. He was also encouraged by ongoing discussions with clinical services, on the basis of which the score in this area was moved from Amber/Green to Green.

On question 2b about the Board's promotion of a quality focused culture throughout the organisation, the score was moved from Amber/Green to Green on the basis of the Quality Strategy implementation, the programme of quality walk rounds and plans to ask clinical services to present to the Board.

On question 4b about the Board's assurance of the robustness of quality information, the external assessors had scored the Trust Amber/Green, more favourably than the organisation had scored itself.

In total, the Trust's reassessment on the 10 domains was made up of 3 Greens and 7 Amber/Greens and an overall score of 3.5. Professor Baker informed the Board that the Trust's internal auditors would be assessing the work that had been done in arriving at these scores in March, and he expressed the intention that all the domains be assessed as Green by the end of March.

Mr Ward commented on the score for 4b and asked if there was a consistent approach to the use of HealthAssure. Ms Walsh responded that the divisions were on target to have populated their domains by the end of March. Over 160 clinical users, including consultants, nurses and scientific staff had been trained to use the system, and were populating it with vast amounts of information She expressed confidence that this timescale would be met and advised that by the end of Quarter 1, the Board would have sight of the evidence supporting to the Trust's declaration and the level of assurance attributed to each piece. Mr Stevens added that the level of data quality assurance within the Trust was increasing, and that all data owners attended the Data Quality Committee. All data was currently held centrally but this would change as HealthAssure was rolled out.

Mrs Tutt acknowledged the intention to reach a total score of 3 by March, but questioned what the overall strategy was. Professor Baker stated that the focus

would be on continuing to improve quality governance within the Trust, asserting that the scores did not determine the Trust's priorities. Mr Salt advised the Board of the likelihood that Monitor would score the Trust more strictly in their assessment. In terms of Board assurance, Dame Fiona reminded the Board that the action plan would be monitored by the Clinical Governance Committee, and that the Quality Committee had sight of their minutes.

The Board resolved to **note** the contents of the report.

TB11/13 Review of Progress against 2012/13 Business Plan

Mr Stevens presented this progress report on the business plan for the year, which would inform divisional, departmental and individual plans and appraisals. It had been timed to inform the Quarter 3 divisional reviews and planning for 2013/14. He stated that overall, good progress was being made, but that performance on CIPs, QIPP and the roll out of the Quality Strategy would need to be sustained.

Mr Cameron acknowledged that this was a good piece of work, but suggested that in some areas it would have been more helpful if it had been made clearer whether the Trust was behind, ahead or on track. Mr Stevens agreed to build this in before the end of year. Mr Salt commented that this was one of the best papers he had seen at a Board meeting, and that it should be used as a template for other papers that were presented. Dame Fiona commended all those involved in preparing it.

The Board resolved to **note** the contents of the report and the progress against the Trust business plan.

TB12/13 Integration with the Nuffield Orthopaedic Centre: Benefits Realisation

Mr Stevens presented this one year post-integration report, reminding the Board that they had previously received an interim report. He commented that the business case for the merger had been largely based on clinical benefits, but that there had been financial benefits as well. He concluded that the integration had been effective, and that the clinical benefits across the whole Trust, such as the spinal pathway, had been recognised by external stakeholders. Mr Stevens added that work was continuing on improving patient pathways, and that other organisational changes were being made, including moving children's services that had previously been delivered at the NOC into the Children's and Women's Division, thereby creating smoother pathways.

The Board noted the positive relationships that existed between staff at the NOC and the wider Trust. Mr Goard stated that he had been involved in mergers and acquisitions in the past where there had been problems culturally, but his experience was that NOC staff remained enthusiastic about being part of OUH. Professor Mant

added that OUH had gained from the NOC in terms of good practice and the patient experience.

In response to an enquiry about the PFI commitment, Mr Trumper stated that the Trust would expect to leverage this in a way that would be beneficial to the whole organisation. It is a fairly small PFI but with numerous overheads. He advised that the turnover dates for the NOC and Churchill PFIs had been aligned to September 2013, which meant that they could be managed with a single overhead. He acknowledged that the longer term position was less certain but the experience to date had been better than expected and it was performing better than the other 2 projects. Sir Jonathan added that the project did not alter the Trust's financial risk profile.

The Board resolved to **note** the report.

TB13/13 Integrated Performance Report Month 8

Mr Brennan presented this report setting out the position at the end of November. He highlighted the continued achievement of the RTT, 4 hour waits and VTE targets, and advised that all the cancer standards had been met. However, concern remained regarding the speciality level RTT. DTOC joint work across the system was continuing, and there were now 101 delays across the system, a major improvement on the position earlier in the year, but still a cause for concern. On finance, Mr Brennan reported that the position across all the headings was that there had either been no change or a slight improvement.

The period over Christmas had been very difficult, such that the Trust had aimed to have 120 empty beds, but ended up with only 30. 121 escalation beds out of 122 were in use over the period, but this had now dropped slightly. These beds are being staffed by permanent employees with a view to maintaining quality. Having so many extra beds open had however had a financial impact on the Trust.

Sir Jonathan confirmed that the previous weekend had been the most difficult of the financial year in terms of the number of patients requiring attention and the severity of their presentations. He acknowledged the advantage of having improved joint working arrangements with local partners including Oxford Health and Oxfordshire Social Services, as everyone concerned had worked around the clock to optimise patient flows. He observed that the financial implications of this surge in activity had been skewed by the national requirement that all non-elective activity above the 2008 level was remunerated at 30% of tariff. This had been recognised nationally as being counter-intuitive.

Dame Fiona suggested that the Trust ought to formally acknowledge the welcome improvement in the quality of partnership working and Sir Jonathan agreed to write

to his opposite numbers in this regard, and also to thank Trust staff for their hard work over the period.

Action (JM)

Communication to be sent to the Chief Executives of Oxford Health NHS Foundation Trust and Oxfordshire County Council, acknowledging the positive impact of improved partnership working over the Christmas period, and Trust staff are to be thanked for their hard work

Ms Donaldson emphasised the importance of thanking staff, and highlighted the fact that two of the three staff experience indicators in the report had been red rated. She commented that significant progress had been made in reducing the vacancy factor, and that it was not unusual for sickness absences to rise at this time of the year. She advised that the year to date figure was just over 3%, and was confident that the Trust would achieve 3.2% for the whole year.

In response to a question as to whether the DTOC number could be brought down to 76 as planned , Mr Brennan stated that this was still achievable, but that this was the most challenging time of the year. He reported that the work across the three organisations was bearing fruit, and that all patient movements were now transparent across the system.

The Board resolved to **note** the contents of the report.

TB14/13 Operational and Performance Report Month 8

Mr Brennan informed the Board that this report focused on performance against the key access targets, which had been addressed in the previous discussion.

The Board resolved to **note** the contents of the report.

TB15/13 Financial Performance to 30 November 2012

Mr Mansfield advised that the Trust remained on course to meet its financial targets for the year, but he acknowledged that the recent activity had made this more difficult. He also remarked that the impact of the 30% marginal fee for non-elective activity above the 2008/9 level would require proactive monitoring. He highlighted as a major risk, the impact of additional emergency activity paid at 30% on the capacity to deliver elective or planned surgery which was remunerated at 100%. Mr Ward referred to the material variances within the analysis of income by commissioner, and questioned whether this would be replicated under the new arrangements. Mr Mansfield responded that the position would be complicated next year as the specialist commissioning arrangements were changing and that the full impact of the

transfer of commissioning responsibility from CCGs to the Specialist Commissioning team of the National Commissioning Board was not yet clear.

On the savings programme, Mrs Tutt noted that the high risk projects were being addressed, and asked about progress on those of medium risk. Mr Mansfield stated that most of these schemes were divisionally led and that there was a robust monitoring process in place. He added that the full year effect would overcome the non-recurrent nature of some of the projects.

The Board resolved to **note** the contents of the report.

TB16/13 NHS Trust Oversight Self-Certification

Mr Stevens presented this report and reminded the Board that when the previous iteration had been presented in November, the Board had agreed to rely only on validated figures. On the basis of the October data submission, the Trust achieved a score of 2.5, which contributed to an overall score of Amber/Green. On receipt of the validated data, it was clear that the Trust had in fact delivered all cancer standards in October, and as such, the overall score should have been Green. Mr Stevens advised that the Trust was in discussion with the SHA on ways to avoid such confusion in the future.

Mrs Tutt referred to Financial Risk Trigger 10 and asked if the Trust was on track to identify 2 years of detailed CIP schemes. Mr Stevens stated that detailed proposals for next year were in place, and that plans were being developed for 2014/15.

The Board resolved to **delegate authority** to the Chairman and Chief Executive to sign off the December submission.

TB17/13 Amendments to the draft Constitution

Sir Jonathan reminded the Board that they had signed off the draft constitution at their meeting in November. Following discussions with the SHA, it had been proposed that rather than specify in the constitution the exact number of executive and non-executive directors on the Board, there should be some flexibility. He advised that he had held detailed conversations with the Director of Assessment at Monitor regarding the size and composition of the Board and there was a recognition that the needs of the organisation could change in future. The advice received had been that the Trust adopts the same wording that had been used by another Trust:

> *"no fewer than five and no more than nine executive and non-executive directors and one non-executive chair".*

This would mean that changes to the size and composition of the Board could be made without the need to change the constitution.

The Board resolved to **agree** the suggested amendment to paragraphs 22.2.2 and 22.2.3 of the draft Constitution, and that paragraph 1 of Annexe 8, Appendix 3 regarding CRB checks for Non-Executive Directors be removed from the draft Constitution.

TB18/13 Annual Review of Standing Orders

Mr Mansfield introduced this paper containing recommended changes to the Standing Orders, Scheme of Delegation and Standing Financial Instructions. He advised that the changes had already been approved by the Audit Committee.

The Board resolved to **approve** the amendments to the Standing Orders, Scheme of Delegation and Standing Financial Instructions.

TB19/13 Non-Executive Directors' Indemnity

Sir Jonathan presented this paper which confirmed the Trust's agreement to provide indemnity for Non-Executive Directors. The Non-Executive Directors declared an interest at the beginning of the discussion. Sir Jonathan referred to the established guidance from the Department of Health as to how this issue was handled.

The Board **agreed** the provision of indemnity for the Non-Executive Directors of the Trust.

TB20/13 Reports from Board Sub-Committee

(a) Audit Committee

Mrs Tutt presented a summary of issues of note arising from the recent meeting of the Audit committee held on 14 November 2012. The Committee's cycle of business had been agreed, and a programme of risk deep dives was to be implemented.

The confirmed minutes from the Audit Committee held on 14 September 2012were attached to the report.

(b) Finance and Performance Committee

Mr Goard presented a report on items of interest and note from the meeting of the Committee held on 12 December 2012. The report covered the Trust's Cost Improvement Plans, indemnity and insurance arrangements and the management of creditors and debtors.

(c) Quality Committee

Mr Salt presented a report on matters of interest and note from the Quality Committee meeting held on 12 December 2012. Mr Salt advised the Board of the intention to hold a detailed discussion on the strength and quality of nurse leadership.

The Board resolved to **note** the contents of the reports and **received** the attached Audit Committee minutes.

TB21/13 Quality Committee Terms of Reference

Professor Baker presented a paper suggesting slight amendments to the terms of reference of the Quality Committee of the Board to clarify the assurance role of the Quality Committee in relation to the Clinical Governance Committee which was a sub-committee of the Trust Management Executive. The amendments had already been supported by the Quality Committee.

Sir Jonathan requested that slight changes be made to the terms of reference of all the Board sub-committees. This is in relation to the calling of meetings, at clause 7 of the Quality Committee's TOR. It was suggested that the second sentence in the clause be amended to read: "…at such other times as the Chairman of the Committee shall identify, subject to agreement with the Chairman of the Trust and the Chief Executive." Sir Jonathan explained that the reason for this amendment was to enable better management of the Committee's workload.

The Committee resolved to **approve** the specific change to the terms of reference of all Board Committees as suggested by the Chief Executive and agreed to the specific amendments to the terms of reference of the Quality Committee.

TB22/13 Consultant Appointments and Signing of Documents

Sir Jonathan presented a regular report to the Board on the use of delegated authority regarding the appointment of consultant medical staff, the signing of documents and the use of the Trust Seal.

The Board resolved to **note** the contents of the report

TB23/13 Any Other Business

Dame Fiona reminded the Board that future meetings in public would start at 09.00 in order to allow sufficient time to conduct the business of the Board. .

TB24/13 Date of the next meeting

A meeting of the Board to be held in public will take place at 09.00 on Tuesday 12 February 2013 in the George Pickering Postgraduate Education Centre, the John Radcliffe Hospital.

The Board then considered and agreed the following motion:

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