Confirmed

Bedford Hospital NHS
NHS Trust

BEDFORD HOSPITAL TRUST BOARD

Minutes of the 151st Meeting of the Bedford Hospital Trust Board held at 10am on Wednesday 31st March 2010 in the Committee Room, Bedford Hospital

Part 1

Present:	Mr R Rankmore, Chairman Mr G Johns Vice Chairman Mrs J O'Callaghan, Chief Executive Mr E J Neale, Medical Director Mrs L Hunt Chief Operating Officer Mr A Warren, Director of Finance and Performance Mr K Lewis, Non Executive Director Mr D Gear, Non Executive Director Mr C Ovington, Director of Nursing & Patient Services Mr I Pickering, Non Executive Director Mr P Hutt, Non Executive Director
In attendance:	Mr A Dickinson, Trust Board Secretary Mrs A Buck, Director of Human Resources

The Chairman welcomed to the meeting observers from NHS East of England.

14/10 DECLARATIONS OF INTEREST

There were no new Declarations of Interest.

15/10 MINUTES OF THE PART ONE MEETING HELD ON THE 27th JANUARY 2010

With the following amendments these were agreed as a correct record.

7/10 Paragraph 1, correct grammar.
Finance - amend over-performance figure to £6.2m.
Performance - add 18 week before pathway.

11/10 amend to "selection for and completion of this demanding one-year course".

MATTERS ARISING/ACTION LOG

73. Estates Strategy - Still on target for completion by June 2010.
79. Financial Turn round - to be covered in Operational Report.
80. Assurance Framework - this would now be presented to the June meeting following the next meeting of the Audit Committee.

Service Line Management - the Chief Operating Officer advised that this had been discussed at the last service line management committee and a paper would be submitted to a future Trust Board on the proposed structure of business units and governance arrangement, together with the milestones for implementation.

17/10 MATRON'S REPORT ON SUPERVISION OF MIDWIVES

Naomi Gallagher, Head of Midwifery and Oonagh Purdy, Supervisor of Midwives in attendance.

The Director of Nursing & Patient Services introduced the presentation by stressing the importance of midwifery supervision in safeguarding patients, the public and staff. The aim of the presentation was to enable the Trust Board to have a better understanding of the role which was statutory and its importance. The Head of Midwifery explained that currently the trust had four supervisors of midwives. To meet the target ratio of one supervisor to fifteen midwives, a further four were required. There was a national shortage and it had been local practice to develop existing staff into this role. One

further supervisor would qualify in June, an existing supervisor had been recruited from elsewhere and would be able to take up the role after full orientation and others were expressing interest. To become a supervisor a midwife had to be nominated by five midwives and complete study to master's level. In the role, supervisor was directly responsible to the local supervising authority (the Strategic Health Authority).

The supervisor of midwives then presented a case study involving a recently qualified midwife whose handling of an epidural anaesthetic had been considered by the anaesthetic registrar involved to be unsatisfactory, particularly in relation to the keeping of records. Care of the patient had been taken over by a senior midwife and no harm had resulted. Following a conversation with a local supervising officer, a Root Cause Analysis investigation had taken place involving two supervisors. Before the investigation could be finalised the midwife in question had gone off sick and the supervisors' investigation had therefore never been completed. The matter had however been reported to the Nursing and Midwifery Council in case the midwife notified an interest to practice elsewhere. In that situation she would need to be assessed before being allowed to practice. The Head of Midwifery advised on the requirements necessary to remain as a supervisor of midwives and the requirement of supervisors to produce an annual report.

The Director of Nursing & Patient Services stressed that the role was crucial to the quality agenda and the importance of increasing the number within the Trust so that the work could be undertaken better. Mr Hutt queried the situation with midwives working in the unit who were not employees and the Trust Board asked for a report on the legal implications of this for the next meeting. Mr Pickering asked about the availability of midwives to provide one to one care in labour. The Head of Midwifery responded that because of the shortage nationally of midwives, roles within the unit were being developed for registered general nurses and maternity care assistants to do the tasks which were not statutorily restricted to midwifes e.g. post operative care, breast feeding support. The Director of Nursing & Patient Services believed that the Trust was innovative in this area. Mr Lewis was assured that no agency staff was used in the unit. Mr Gear queried whether there were any issues in relation to the split accountability of the supervisor. The supervisors confirmed that in their view there was no such conflict and that the roles were complementary and led to high professional standards. Although reports from the local supervising officer were confidential, lessons learned from incidents were included in the annual report.

The Chairman thanked the supervisors for their report, saying that he felt assured that arrangements were in place to maintain high standards and he encouraged the supervisors to continue their good work.

18/10 ASSESSMENT OF BEDFORD HOSPITAL AGAINST THE FINDINGS OF THE FRANCIS REPORT INTO FAILINGS AT MID STAFFORDSHIRE NHS FOUNDATION TRUST

The Director of Nursing & Patient Services introduced his report, stressing that it was not a summary of the Francis Report but aimed to reassure the Trust Board that the issues involved at Mid Staffordshire had been looked at and were being dealt with appropriately within this Trust. He could not guarantee that it would not happen but confirmed that there were systems and processes in place to protect patients that were checked by e.g. the Patient Safety Committee. The Chairman commented that the issue in Mid Staffordshire was that systematic failure was not recognised by the Trust Board because systems did not identify the problems and the Board did not listen to what patients said. He did not believe that that would be tolerated in Bedford but advised all Board members to read the patient's stories in the Francis report. Mr Johns felt that the Board should keep before it the principle of providing only high quality services and this should be as important as financial implications when the Board considered its strategy. He then asked for specific assurance in relation to professional training, multidisciplinary working on wards for elderly patients and nursing principles. The Director of Nursing & Patient Services advised that there was concern at the current

losses from the University of Bedfordshire nurse training courses and this was being pursued with the University. The new *Personal Best* training programme would encourage staff to think through issues. He confirmed that there were weekly multidisciplinary team meetings on wards caring for older people, but that more work needed to be done, particularly in relation to dementia. The issue of principles for nursing was covered in the Nursing Strategy, for discussion later on the agenda. The Chief Executive commented that she did not believe events in Mid Staffordshire could happen in Bedford because of open reporting, regular reviews of mortality, the Trust's assurance processes and staff mix. She confirmed that she personally saw complaints and although there were examples of a range of issues, there was no overall pattern. What was important was not accepting the unacceptable. The Medical Director advised that in relation to medical input, standards for specialties against which the Trust was measured were published and there were good processes in place. There had been good discussion of the report at the hospital's Medical Staff Committee and recognition that ultimate responsibility lay with consultants. The Chief Operating Officer commented that she did not believe the organisation was being pressed to hard. There were plans in place for dealing with winter pressures and the arrangements were managed. Staff were involved in the process, particularly through the service redesign approach. The Trust had increased the number of clinicians in Accident and Emergency Department and on the Acute Assessment Unit and now there was a multidisciplinary assessment of all patients on the Acute Assessment Unit within four hours. Targets were met but were met efficiently. The Director of Human Resources advised that current educational provision was being reviewed as not all training required was currently available locally. The Medical Director referred to benchmarking data and to the Trust's policy for raising concerns.

The Chairman stressed that the Board was determined not to accept the unacceptable, that patient safety was a top priority for the Board, that the board was not complacent and should receive a quarterly report on the recommendations to ensure that there was no loss of focus. The work should continue through the Patient Safety Committee and the Medical Staff Committee.

19/10 ANNUAL SURVEYS OF PATIENTS AND STAFF

Dr Reg Race, Managing Director, Quality Health, in attendance.

The Chairman welcomed Dr Race to the meeting to give his annual report on the two surveys. On the patients' survey Dr Race drew attention to the fact that five of the questions would in future provide the benchmark for CQUIN payments and the PCT was able to deduct money from the Trust if there was no improvement in these areas. It was now possible to give comparisons over the period 2004 to 2009 and in a number of areas nationally, except in relation to cleanliness, there had been little change eg

- in relation to patients' understanding of the answers given by nurses and doctors,
- the quantity of information given generally and
- the information given about the side effects of medication.

Overall in the 2009 survey, the Trust had stayed as it was and had dropped back in cleanliness, confidence in doctors, information on treatment, care overall, feeding of patients and whether there were enough nurses on the ward. The only area where the trust was on average was catering. The area where the Trust had made progress and was above average was in relation to single sex accommodation, where it scored highly on all three indicators.

Because of the low scores he felt it would be easier for the Trust to make progress on the CQUIN indicators and suggested that priority should be given to looking at discharge information, delays in discharges, side effects of medicines and who to contact if problems arose after treatment. The Board generally was disappointed by the results. Mr Johns was particularly concerned as the Trust's deterioration was not reflected nationally. The Chief Executive commented that measures introduced such as protected meal-times and red trays clearly were not having the desired effect. Mr Hutt was puzzled by the discrepancies between the figures in this survey and the figures

revealed by the Trust's own surveys. Dr Race felt this might be linked to the timing of local surveys and surveyor involvement in them. He and the Medical Director drew attention to factors in the breakdown of those surveyed which might skew the results unfavourably e.g. the ethnic population and the number of patients who were emergency admissions. The Director of Nursing & Patient Services felt that the messages from both surveys should be accepted, even though findings on cleanliness were not in line with those of the Care Quality Commission visit. More needed to be done, perhaps differently. Mr Johns felt that the survey reflected the approach of many staff to customer service. The Chief Operating Officer wondered how far unsatisfactory aspects at the time of discharge influenced patients' appreciation of their whole stay. Mr Pickering asked about the ability to drill down into the data to get more specific information as to what issues were of concern and was advised that patient comments were available. Dr Race then stressed the importance of knowing what was important for patients –

- faster treatment,
- a convenient hospital,
- good clinical outcome,
- good explanation of what happened and
- how they could get help afterwards if there were problems.

The Chairman stressed the strategic importance of improving the patient experience so that patients continued to choose the hospital. The Chief Executive agreed that it was necessary to review the actions already in place, particularly in view of complaints about bedside communications, focus on discharge and develop action plans at divisional level which could then come to a future Board meeting. The Chief Operating Officer suggested a Task Force approach to the issue.

On the staff survey, Dr Race reported that the position was considerably different, as this showed considerable improvements, particularly in relation to training, appraisal, patient focus, communications and reporting of errors. Nationally, staff survey scores had remained static or had deteriorated between 2003 and 2007. 2008 had seen an improvement and this had been maintained into 2009, in particular with more training being done, particularly on Equality and Diversity, an increase in the number of appraisals, PDPs, reduced numbers of staff thinking of leaving and improved job satisfaction. Against other acute trusts, the Trust was
above average on

- work life balance,
- having clear goals,
- valuing staff work,
- involving staff,
- communication to staff what the organisation what the organisation was trying to achieve,

on the average in relation to

- work related stress and appraisals and

below average on

- meeting conflicting demands,
- priority given to care of patients.
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Again, further information was available to identify specify areas/issues. Mr Lewis welcomed the improvement in the number of appraisals but stressed the need to make further progress. The Director of Human Resources advised that she was currently looking at blocks to this, such as spans of control and the paperwork in use. Mr Hutt asked about training needs and the Director of Human Resources advised that these were usually identified through the personal development plan process. Mr Lewis understood that there was an issue in relation to back-fill. The Chief Executive welcomed the progress made as a result of considerable efforts made to improve communications with staff and stressed a need to adopt a similar approach in relation to patients. The Chairman stressed the difficulty of continuing to make progress in view of the pressures of the current economic situation. Dr Race was thanked for his

presentation and withdrew.

20/10 STRATEGIC SCORECARD

Mr Gear asked how the Trust had achieved its very impressive performance in relation to organ donation. The Medical Director advised that this was due to the work of Dr Jane Hurst, Transplant Coordinator and her team and their compassionate communication with relatives of dying patients. It was important to see how the lessons learnt from this could be used in other areas of communication. The Chairman asked for more details of the work being done on the decontamination unit and was advised that the layout work related to the existing building and was assured that there would be no cross flows involved. The board was disappointed with the progress with devolving the provider unit. The Medical Director reported on a county-wide event he had attended where key areas for significant progress in improving patient experience had been identified. The report was noted

21/10 SINGLE EQUALITY SCHEME

The Director of Human Resources drew attention to the statutory requirement to develop a single equality scheme covering age, disability, gender, race and religion or belief and sexual orientation. The current document drew on the Trust's existing strategies for race, gender and disability. The strategy was supported by three-year action plans. Mr Hutt advised that the initial emphasis would be on employment issues and then on patient centred areas. Mr Johns was assured that the Trust met current legislative requirements. The Medical Director queried the requirement for equality assessment in all policies and was advised only screening was required, with a full impact assessment being undertaken only where the screening indicated there were potential implications. The Chief Executive drew attention to the governance arrangements and subject to amending those to match the Governance and Risk Policy approved at the Board's previous meeting, the Board **resolved** to adopt the Single Equality Scheme. The Chairman found the good practice examples particularly helpful.

22/10 NURSING AND MIDWIFERY VISION AND CONTRIBUTION TO DELIVERING *EVERY PATIENT MATTERS*

The Director of Nursing & Patient Services explained that the purpose of this document was to inform the board about the ambitions within the nursing and midwifery professions, to improve the quality of care offered to patients and to get Board support for the ten pledges. A copy of the strategy had been sent to all wards for them to prepare an action plan and all nurses would be expected to use the strategy as a basis for their individual appraisals/personal development plans. The project was linked to the productive ward and the knowledge and skills framework. The document had been prepared with considerable input from Matrons and his deputy and had been the subject of consultation. Ward action plans would be shared at the next Sisters' Meeting and a strategy group established to oversee its implementation. The Chief Executive felt that the strategy helped to give confidence about standards and the culture within the Trust and referred to the wide representation present at the strategy's launch.

The Board unreservedly supported the document and endorsed the vision. Individual board members subsequently signed the pledges.

23/10 OPERATIONAL REPORT

The Chief Executive advised that thanks to the considerable efforts made over the past few weeks, it now looked at if the Trust would break even for the financial year and that all standards had been met. She advised that Milton Keynes had withdrawn from the proposed collaboration with other acute trusts in the growth area corridor but the wider work was continuing. A formal announcement was still awaited from the Healthcare Commission but the expectation was that the trust would be registered without conditions. The post of Director of Nursing & Patient Services had been offered but the successful candidate had yet to confirm her starting date. At a meeting she had attended with Bedford Adult Social and Healthcare Policy Review and Development Committee, a number of examples had been quoted of bad experience around patient appointments. These were being looked into and addressed and a further report would

be made to the Board.

Finance
The Director of Finance and Performance advised that although at the end of month 11 the Trust was still in deficit, he was reasonably confident that at the end of month 12 the Trust would be a break-even, partly as a result of the *Every Penny Matters* campaign. Technical adjustments would lead to a bigger surplus. Some of the actions taken would not be sustainable into the future but others might be and turnaround would continue, to oversee the implementation of cost improvement programmes. The Chairman congratulated their staff on their outstanding engagement which needed to be maintained. Mr Johns asked for the Board's appreciation of their efforts to be conveyed to everybody and an appropriate way of celebrating be devised.

Performance
The Chief Operating Officer advised that activity in February had been low because it was a short month. There had been some Norovirus problems but these had been manageable. Emergency admissions had been high but standards had been met in the Accident and Emergency Department. She drew attention to issues in relation to two cancer targets: in relation to breast symptomatic patients, the issue was the impact of patient choice. This issue was being raised with the cancer network and an appeal would be made to the Care Quality Commission. There were also discussions taking place with General Practitioners about the level of information to be provided at the initial consultation. Cancelled operations remained an issue, although there had been an improvement, especially in cancellations for non-clinical reasons. She drew attentions to the extra 84 patients treated in theatres because of improved scheduling which had involved no additional costs. This was as a result of the transformation project. Although there was still an excess of repeat outpatient attendances, discussions were taking place with the commissioner in relation to follow ups in four specialities. In Trauma and Orthopaedics services, joint follow up would take place by hospital staff in a community setting and as a result of the LEAN review of booking processes, a single booking centre was being established. This would facilitate making better use of the follow up capacity.
Mr Pickering drew attention to comment in the audit report on performance that more information should be provided in the board report on action to be taken where performance standards were not achieved. The view of Audit Committee members had been that this information was given at Board meetings and also covered in the monthly Governance and Monitoring Report. The Board agreed that sufficient information was provided in the existing report.
The Chairman queried how the good performance linked to the comments made in the inpatient survey. The Chief Operating Officer confirmed the importance of providing a good patient experience and outlined the steps she was taking to monitor *Every Patient Matters*. One key element would be arranging discharges before midday. Responding to questions from Mr Lewis and Mr Johns, she confirmed that information was available at shop floor level and that the issue of discharge medication was a symptom of a wider problem.
The Chief Executive advised that the performance in the Accident and Emergency Department was the second best in the region. The Chief Operating Officer advised that a new target for 18-week waits would apply from the 1st April where the only allowance was in respect of patient choice and not capacity. It was important therefore that the contract reflected demand. Orthopaedic surgery was a particular issue and the PCT review had yet to be completed, which was disappointing as there were issues in relation to muscular-skeletal triage service. She confirmed that there was adequate capacity in other specialties for the level of activity currently proposed.

Work force
The Director of Human Resources drew attention to the work taking place to reduce agency and locum costs, by filling vacancies and adopting a flexible approach to appointments. Divisions would be producing plans to reduce the overall head-count.
Mr Johns asked about the factors contributing towards a reduction in sickness levels

and whether the lessons were being learnt. The Director of Human Resources advised that she believed this was due to better management control, which would be continuing. The Director of Nursing & Patient Services drew attention to the reduced sickness and absence on productive wards as a result of greater involvement and better information. Twelve wards were currently covered by the project and all would be covered by the end of the year.

Patient safety

The Medical Director invited further comments on the revised presentation of the report. He confirmed that there was consistent improvement in the areas of mortality which had previously been highlighted and drew attention to the new arrangements for DVT to be introduced from the 1st April. Mr Pickering asked about the Trusts identified by the Care Quality Commission as outliers in respect of mortality. The Director of Nursing & Patient Services advised that while the names had not been announced it was clear from looking at Dr Foster figures which the Trusts were. Bedford Hospital appeared in the 'expected' band on NHS Choices. The Chairman stressed the importance of seeing improvements in the Trust's mortality figures.

Mr Lewis stressed disappointment at the low rate of returns on pressure ulcer incidence. The Director of Nursing & Patient Services advised on the measures he was taking to secure improvements in this area as there were now financial disincentives applying to patients who developed pressure ulcers during stays in hospital.

The Chairman asked about progress with providing a 24-hour patient at risk (PAR) Team. The Medical Director advised that there had been a review of anaesthetic training including critical cTB 31 March 2010 Part 11.are by the Royal College of Anaesthetists and PMETB and a repeat visit would take place in November. There was a need to look at the utilisation of resources. There would however in the interim be extended nursing hours and an electronic hospital at night system to alert critical care of patients at risk.

Infection prevention and control

Mr Johns expressed disappointment that hand hygiene targets appeared to have plateaued. The Director of Nursing & Patient Services advised that there had in fact been improvements over the last two weeks. In relation to time to isolate, he advised that this was linked to the number of side rooms available. The priorities for their allocation were clostridium difficile, Norovirus and patients colonised with MRSA. Where a group of patients were cohorted in a bay on a ward, that counted as being isolated. Mr Pickering drew attention to the new method of identifying MRSA reported in the press the previous day. It was agreed that this should be pursued.

Patient experience

The difference between the national patient survey and the Trust's own surveys had previously been identified. The local survey indicated that the 98.4% of patients would recommend the hospital to others. One factor might be the time delay as the national report related to patients admitted in the summer of 2009.

The report was received

24/10 SERVICE LEVEL AGREEMENT WITH NHS BEDFORDSHIRE

The Director of Finance & Performance advised that technically the Trust still had a Service Level Agreement with NHS Bedfordshire as the one entered into from 1st April 2009 was a three-year contract and current negotiations were in relation to a deed of variation. Because of the late receipt of proposed activity figures and the need to discuss these with local clinicians, it would be at least another week before agreement could be reached.

Mr Pickering queried therefore whether notice should be given at this stage that the GUM service would terminate. The Director of Finance & Performance confirmed that this was one of the elements being discussed in the negotiations and it was agreed that a decision be deferred until the total picture was clearer. The Chairman stressed the importance of retaining non-profitable services only if they were of strategic value.

He considered the current position unsatisfactory and he had spoken to the PCT

Chairman about the issue. The Director of Finance & Performance confirmed that the offer made by Horizon on behalf of the PCT was consistent with the budgets he had put forward and the figures were unlikely to change downwards as no developments were included. The Chief Operating Officer expressed concern about the profile of activity which did not match local trends e.g. conversion rates. While overall figures balanced, each individual specialty needed to be accurate and clinicians' views had not yet been fully reflected in the plans.
The Director of Finance & Performance confirmed that the Trust had taken legal advice on its position and had noticed a change in attitude and approach which was continuing. As yet there were no disputes. Because there was a contract in existence the Trust would continue to be paid at 2009/10 levels. Mr Pickering queried whether cash pressures were affecting the negotiations. The Director of Finance & Performance advised that the current proposal was for a financial cap at the range of 97-103%. This had not been accepted as no demand management was in place and capacity reviews had not been completed, it was anticipated was that activity would be greater than 103%. The Board stressed the importance of not incurring penalties from having unrealistic plans and asked that performance notices be issued as necessary throughout the year.
The Board noted the position. In terms of signing off the agreement, the Board agreed that this could be done either at the April Finance Committee or at the April Board meeting. Both the PCT and the Strategic Health Authority should be informed of this timescale.

25/10 **APPROVAL OF BUDGETS 2010/11**

The Director of Finance & Performance confirmed that the budget presented for approval contained income consistent with the PCT's offer and the break-even out-turn was consistent with the Integrated Business Plan. Service developments were included in the reserves. He drew attention to the introduction from the 1st April of residual budgeting, which would ensure better budgetary control. Cost improvements had been built into the budgets. While revisions were likely he felt it was important that budgets were approved and issued at the beginning of the financial year. The proposed capital programme varied from the one in the Integrated Business Plan to reflect slippage in 2009/10. The Director responded to questions from the Medical Director, Mr Johns and Mr Pickering on particular aspects, recognising the initial budgets would probably need revision once the Service Level Agreement had been agreed.
The Board **resolved** to approve the budgets, including the capital programme, as submitted and to them being issued to managers.

26/10 **ANNUAL PLAN 2010/11**

The Director of Finance & Performance explained that the plan as submitted used the NHS East of England template which matched the requirements that Monitor set for Foundation Trusts, although the submission deadline was earlier than that required by Monitor. This year's plan contained new sections on quality and QIPP. The review of 2009/10 contained in the plan would also form part of the annual report. The proposals for 2012/13 were based on those set out in the Integrated Business Plan. He confirmed that figures in section 4.5 linked to the budget and to the Integrated Business Plan. The Chief Operator Officer provided clarification of section 5.2. Mr Hutt suggested amendments to paragraph 9.1.1, Mr Johns asked for further development of the responses in sections 5.2, 5.3 and 5.4. The Trust Board discussed whether in view of the comments made previously about the Service Level Agreement, this should be regarded as agreed or not and it was decided to leave it as "agreement outstanding".

The Board **resolved** that., subject to the comments made earlier, the Annual Plan for 2010/11 and the declarations and self certifications statements in section 13 be agreed and submitted to the Strategic Health Authority by lunchtime the following day, with the updated draft circulated to directors. Any further updates, particularly in relation to income, would be submitted to the Strategic Health Authority later.

27/10 **GOVERNANCE RETURN AND NON-FINANCIAL RATINGS - MONTH 11**

The Board **resolved** that the declaration as submitted be signed by the Chairman and submitted to the Strategic Health Authority.

28/10 DELIVERING SAME SEX ACCOMMODATION

The Director of Nursing & Patient Services advised that the Trust Board was required to receive the Declaration of Compliance with the delivery of same sex accommodation and support the publication of the statement on the Trust's web site to demonstrate to patients and the public progress in promoting privacy and dignity. The Board, while recognising there was still an issue in relation to Critical Care, appreciated the exceptional progress made in this area, thanks to the efforts of the Director of Nursing & Patient Services and others. The success of the work to date had been clearly demonstrated by the results of the patients' survey. It was however an important area as, from the 1st April, breaches would result in a financial penalty. The Board **resolved** to receive the declaration and support its publication on the Trust's web site.

29/10 REPORT FROM THE AUDIT COMMITTEE

Mr Pickering, as Chairman of the Audit Committee, presented the report of the meeting held on the 23rd March. The Committee had supported routine revision of the *Meeting the seven principles of public life* policy, had reviewed the draft of the Statement of Internal Controls and had been disappointed to note that three draft Internal Audit reports offered only limited assurance. This could have an impact on the Head of Internal Audit's opinion. The area causing most concern was that relating to discharge summaries. The Director of Finance & Performance advised that the Trust had now received details of the discharge summaries identified in the PCT's audit as having not been received by GPs and these were being followed up to check the position and minimise any potential clinical risk. The Committee had also put in place arrangements for improved links with clinical audit, by receiving outcome reports.
The board received the report and supported the principles in the policy, noting that JSMC approval to it was still awaited.

30/10 DATE OF NEXT MEETING

The next public meeting of the Trust Board will take place at 10am on Wednesday 26th May 2010.

31/10 EXCLUSION OF THE PRESS AND PUBLIC

The Board resolved under standing order 3.17.1 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 matters to be transacted, publicity on which would be prejudicial for public interest.

Members of the public were present at the meeting and members of staff were present for the presentation by Dr Race.