

Trust Board

TB2008.67

Minutes of a meeting of the Trust Board held in public on Thursday 24 July 2008, in the Stable Block Committee Rooms, at the John Radcliffe Hospital.

Present:	Sir William Stubbs	In the Chair
	Mr Trevor Campbell Davis	Chief Executive
	Dr Ken Fleming	Non-executive Director
	Mr Chris Hurst	Director of Finance & Procurement
	Ms Caroline Langridge	Non-executive Director
	Dr James Morris	Medical Director
	Dr Colin Reeves	Non-executive Director
	Mr Brian Rigby	Non-executive Director
	Mrs Elaine Strachan-Hall	Director of Nursing & Clinical Leadership
	Mr Andrew Stevens (part)	Director of Planning & Information
Attending:	Dr Melanie Darwent (part)	Lead Consultant for Emergency Departments
	Mr Oliver Francis	Media & Communications Manager
	Mr Andrew Murphy (part)	Director of Performance Improvement
	Mrs Megan Turmezei	Assistant Director of Governance
	Mrs Jenny Kitovitz	Acting Board Secretary
Apologies:	Dame Fiona Caldicott	Non-executive Director
	Dr Henry Reece	Associate Member
	Professor Adrian Towse	Non-executive Director

Action

Declarations of Interest

There were none.

TB 47/08 Minutes of the meeting held in public on 29 May 2008

The following paragraph would be added to page 5: "In response to a question from another member of the public concerning accreditation of ORH pathology laboratories, the Chairman agreed to inform the member of the public of the current status of the laboratories' accreditation." Otherwise, the minutes were agreed as a true record.

TB 47a/08 Matters arising

Noted.

TB 48/08 Chief Executive's Report

The Chief Executive noted from his report (TB2008.48) that:

- Chris Hurst would report on financial performance in Month 3.
- The Trust's Foundation Trust application would be discussed

later on in the meeting.

- Lord Darzi's Next Stage Review, recommending the creation of a small number of Academic Health Science Centres, was timed to coincide with the 60th Anniversary of the NHS. A report about the national and local implications of the Darzi report for the ORH would also be brought back.
- The Horton Hospital would also be discussed.
- He was pleased to announce that Sue Donaldson would join the Trust on 1 November as Director of Human Resources & Organisational Development.
- The Trust has been designated as one of two UK centres to perform adult intestinal transplants. Andrew Stevens confirmed that this would increase the Trust's portfolio of services and that income would be nationally-funded.

AS

TB 49/08 Financial performance to 31st May (Month 2)

Chris Hurst introduced the report (TB2008.49). He reminded the Board that Month 1's surplus had been marginally below plan, in comparison with the budget profiled using the new (day related) income profile. Pleasingly, May's surplus was exactly on plan, which had been a shorter operating month and therefore been set a lower income and surplus target compared to April. For the second month, PCT income is running above plan which meant the Trust is maintaining more capacity than had been anticipated. It is working with the PCT to identify ways to reduce service demand.

The ORH has achieved £2.3m surplus against a planned year to date surplus of £2.5m. Chris Hurst commented that the £0.2m variance is not material. Private patient figures remain on target but significant growth is targeted for later in the year and this is recognised to be a risk. He reminded the Board that the principal risks to the full year surplus are the need to ensure productivity gains and other cost improvements are achieved and the outcome of the work the Trust is doing jointly with Oxfordshire PCT to support the Activity Management Plan.

The Month 2 report provides detail of the year's performance improvement and cost reduction programme. The plan is structured around three areas of focus - productivity, value for money and workforce development. After two months, the Trust is on target. Significant effort has gone into this plan and into further developing the overall project governance arrangements. Ernst & Young have carried out the first review of the plan and confirmed the areas of risk identified by the Trust. They will be re-reviewing the plan before producing

their final report.

In terms of divisional performance, Chris Hurst pointed out that the Division B £800k adverse variance is largely driven by the extra costs of running extra theatres sessions for the all three divisions. The Trust will be able to understand and report this variation more meaningfully when it has put in place patient level costing later this year. He also noted that increases in energy costs have been incorporated into the Month 2 Estates' forecast and that funding for the BRC rises to £11.96m in this year.

The £40m Capital Programme is on target, with £4m having been spent to Month 2. In commenting on Balance Sheet movements, Chris Hurst pointed out that the Trust has re-indexed its assets, Debtors have reduced by £8m in the month, and that over 90% of suppliers were paid within 30 days. He also informed the Board that he would be enhancing the cash management section of the report in the next few months to show a rolling forecast of cash.

Brian Rigby asked if the workforce initiatives within the PICRP were likely to be contentious. Chris Hurst replied that he did not expect this to be the case as the Trust continues to use some temporary staff, which allows for some future flexibility. In answer to a question about the potential "credit crunch", he confirmed that the Trust continuously monitors its suppliers.

It was noted that some consultants are involved with the patient level costing project, which is running a few months behind the plan. Andrew Stevens added that this project linked with the data warehouse development and a timetable would be brought to a future Board meeting. This initiative would also be supporting the Trust's service line management work. He expected patient level costing to take around six months for the initial implementation - that is, with initial reports become available by the end of Q4 this year.

Colin Reeves asked about the joint activity management programme. CH confirmed that this work is being done jointly with the PCT and is that while the NHS aims to minimise patient waits this has to be done in an affordable and manageable way for PCTs. It was noted that consultants provide important feedback to GPs and the PCT, and should have some success in influencing the position. Because of its financial pressures, the PCT has requested changes to dermatology referral patterns. The Trust is forecasting at Month 2 that it expects to carry out circa £17m of additional work, across all commissioners. Andrew Stevens confirmed

that there is less risk with other PCTs and the Trust has been asked to take on more work by Warwickshire and Leicestershire. While it has no control over the rise in visits to A&E, consideration is being given to managing activity for five other specialties: gastroenterology, cardiology, urology, ENT and ophthalmology, and the Trust has arranged meetings to consider what can be done.

Colin Reeves commented that efficiency savings of more than £22m could be hard to achieve from productivity measures as much work had already been done on lengths of stay. Chris Hurst commented that the Trust is receiving the full year value from work carried out in the latter part of last year, and should also benefit in this year from new work. Colin Reeves observed that it was a large programme, as ever, and back-loaded. Chris Hurst replied that the majority of the plans were targeted to contribute throughout the year, but the workforce savings were not scheduled to payback until later in the year.

Andrew Stevens confirmed that the Trust and PCT hold formal meetings every month to identify the areas where activity is running over contract. The Trust has received a specific request from the PCT to change waiting times, and is involving GPs and clinicians in these discussions too. The Trust hopes to influence GPs through these clinical discussions.

In respect of a question from a member of the public, it was noted that relations with GPs are the primary responsibility of the PCT, and Elaine Strachan-Hall volunteered to liaise with the PCT.

The Chairman concluded that finance was looking favourable at this point. CH then talked to the Month 3 Flash Report he had distributed before the meeting. Month 3 figures had just become available and in Month 3 the Trust was continuing to see more patients than planned and consequently income was higher than plan and the Trust's year-to-date surplus was now £600k favourable to plan. The Board agreed that it would consider in private the case for varying its full year forecast.

TB 50/08 Service performance to 31st May (Month 2)

Andrew Stevens noted that the performance management reports were still being revised to conform to best practice and in readiness for FT status.

Customer Focus - Although overall performance is reasonable, The key focus of management attention remains emergency access. It was noted that performance against the A&E 4 hour total wait indicator was now above the target level. However, two areas of concern are fractured neck of femur, and the

percentage of non-electives operated < 24 hours. Professor Willett will bring an action plan for the former to next week's Executive Board meeting. The Board asked to be kept informed of progress.

Productivity and Improvement - Performance in this domain was more variable reflecting the fact that the Trust has set itself stretch targets as part of the Performance Improvement Programme. Caroline Langridge queried that lengths of stay were amber, but Andrew Stevens replied that this was against the Trust's own internal target. While the May figure has risen slightly, the Trust has reduced lengths of stay significantly over the last two years, in a very short time.

Quality & Safety - The Board noted performance against the quality indicators with particular attention being paid to the healthcare acquired infection indicators. For data quality, the Trust exceeded the national ethnic coding target, achieving over 90%, but is still targeting a more stringent 95%+target in order to support the diversity agenda.

Workforce - The sole red indicator relates to the timing of consultant appraisals. This was being addressed as part of the overall strengthening of the appraisal process within the Trust.

Brian Rigby praised the new format.

The Chairman reported that the Chief Executive and he had attended a series of meetings to discuss delayed transfers of care with the PCT and Oxfordshire County Council. Delayed transfers are currently around 50, but need to reduce to below 30. The Trust is striving with its partners to manage the number down, and has increased the pressure to reduce the figure to below 30.

The Chairman added that there had also been concern about the time in assessing ongoing care on leaving hospital. The Trust needs to meet an average of 33 delays throughout the year, which means it needs to reduce to around 23 - 25 for the rest of the year. This very important target has not been achieved for some years. Colin Reeves asked if the Board should express its concern at the lack of progress. The Chairman and Chief Executive agreed they would do so on behalf of the Board.

TB 51/08 Horton Hospital - interim plans for children's and maternity services

Andrew Stevens reported that Oxfordshire PCT established "the Better Healthcare Programme" to progress the recommendations of the Independent Reconfiguration Panel.

The paper deals with the interim plans for the next two years, which have been developed through discussions and workshops involving Trust staff both from the Horton and the John Radcliffe, the PCT and GPs. Essentially, these are:

Children's services

- To maintain current staffing arrangements, supplemented by additional staff grade doctors and consultants. Move to a hybrid rota of staff grades, consultants and locum consultants if middle grade doctors with sufficient experience cannot be found to staff the out of hours rota.

Maternity services

- Seek to retain training recognition for middle grade doctors, increase supervision and promote integration by appointing an additional consultant.
- Provide additional anaesthetic support by creating a second formal on call rota.
- Move to a hybrid rota of staff grades, clinical fellows, consultants and locum consultants if training recognition is lost and middle grade doctor with sufficient experience cannot be found to staff the service.

There are core and contingency proposals. The full year cost of the core proposal is £1.3m, which will be split on a 50:50 basis with the PCT. If there is a need to resort to the contingency plan, the Trust will discuss the funding of the additional cost with the PCT.

The Trust does rely on non-training posts for paediatric services, and at present there is confidence that these are sustainable. A key risk relates to the retention of training recognition for posts in obstetrics.

A workshop to design the service strategy was held on 18 July.

Caroline Langridge said she supported the proposals. However, she would not want extended locum appointments to be made and hoped that the Trust, while operating in accordance with the relevant employment framework, would be able to appoint a woman consultant obstetrician & gynaecologist, recognising the specific needs of the communities served by the Horton.

Andrew Stevens promised the Board would receive the executive summary of the North Oxfordshire Needs Assessment, once available. This extensive document, which was currently being checked, should inform the service strategy.

Colin Reeves asked how robust the interim plans were.

AS

Andrew Stevens replied that they very much depended on the successful recruitment of staff. James Morris added that a major factor is how changes in junior doctor training evolve, which will reduce the pool of people available. The Trust was seeking to be innovative in the construction of jobs in order to attract candidates. For example, it was linking with the Horton ISTC in relation to the recruitment of anaesthetists. The next stage is to implement the plans.

The Chairman said he would write to convey the Board's best wishes David Lindsell, who was on sick leave. Andrew Stevens confirmed that Amanda Middleton and Anne Thomson were taking the lead in David's Lindsell's absence.

WHS

It was agreed that the Board would be kept informed of the progress of the "Better Healthcare Programme".

TB 52/08 Emergency Department performance (clinical presentation)

TB 52a/08 The Chairman thanked Melanie Darwent and Andrew Murphy for their presentation. It was agreed that they would return with an action plan in the autumn.

AM

TB 53/08 The Final Report of the NHS Next Stage Review (Darzi)

Additional information would be brought back later on in the autumn.

AS

TB 54/08 Annual Health Check 2008/09

Elaine Strachan-Hall introduced the first of a regular series of reports to the Board on compliance with core standards and the new indicators (previously known as new and existing national targets). The reports were intended to provide assurance to the Board during 2008/09 and hence contribute to the ORH's annual declaration on core standards.

The Board noted the current compliance across all core standards and compliance against most indicators and noted that those not shown as compliant fall into two categories: firstly, those for which the indicator is not yet known or the measurements will be made later in the year, and secondly, a small number on which work will continue to ensure compliance throughout the year. The Board will continue to receive reports throughout the year; the position on ALE would be included in future reports.

TB 55/08 Board Assurance Framework 2008/09

The Board Assurance Framework (BAF) is used to assure the Board that the risks to the ORH's principal objectives each year are identified, that controls are in place, that assurances are being sought and that any gaps in controls and assurances are

being closed throughout the year.

The Board is asked to note that the BAF for 2008/09 is derived from the same four strategic aims as in 2007/08 but that the objectives from the Business Plan for 2008/09 have been included. The BAF is mapped to the Healthcare Commission's core standards, the Trust Risk Register and the Top Risks being presented to the Board for review. The BAF will be reviewed each quarter with updates being received from the divisions and corporate directorates.

The action plans included within the BAF show that currently there are adequate controls and assurance mechanisms in place to assure the Board that the Trust's strategic objectives are being met at this point in the year.

It was agreed that the Governance Committee, which received the draft BAF for 2008/09 in March, will continued to monitor the BAF quarterly on behalf of the Board, and that the BAF will be next reviewed by the Trust Board in January 2009.

TB 56/08 Trust Key Risks

Elaine Strachan-Hall said the key risks had been drawn from the Trust Risk Register which brought together all risks within the Trust scoring 16 or over. Executive Board had reviewed the Register drawn from the risk registers from the divisions, the corporate directorates and other significant areas including infection control, performance improvement, medicines management and relocation. These 16 risk registers had been reviewed with the result that a number of risks have been removed and new risks have been added after their identification and assessment.

Executive Board undertook a further review to provide the Board with the 'Key Risks'; risks that, if not mitigated, could compromise the activities and strategic aims of the Trust. The groupings took account of individual risks and the risks already included within the Board Assurance Framework (BAF) and the Integrated Business Plan now being prepared for the FT application.

It is proposed that these key risks (which are referenced to both the Trust Risk Register and the BAF) are reviewed regularly by the Board and that the bi-annual review and update by Executive Board continues.

It was confirmed that issues relating to decontamination which had been highlighted when considering compliance with the Hygiene Code and preparing for the HCC inspection had been addressed.

Recruitment spots and other staffing issues had been identified within the risk 'operational capacity and performance'. Caroline Langridge enquired whether the new adult congenital cardiac appointment had yet been advertised. James Morris promised he would check and advise CL.

JM

Colin Reeves enquired how these 10 key risks fitted in with the red risks facing the Trust as a whole. Elaine Strachan-Hall replied that the 70 or more risks which had been considered last time by the Board in the Trust Risk Register had been aggregated into this smaller number of key areas following review by Executive Board. The fuller and updated Trust Risk Register remained in place and would continue to be updated. A well established methodology had been used across all areas of the ORH to score risks. The validation and aggregation by Executive Board was intended to ensure consistency of approach and assessment. Board members could be assured that all red risks had been included within the top key risks.

It was agreed that the Trust Key Risks would continue to be monitored by the Board throughout the year. The Board noted that the detailed reviews within the divisions and directorates would also continue and the outcome of these reviews would be reflected in the updated Trust Key Risk reports to the Board. It was also noted that updates to the Trust Risk Register would also feed into the BAF as it was updated throughout the year.

TB 57/08 Patient Safety Framework 2008 – 2011

Elaine Strachan-Hall introduced the framework and highlighted its importance in supporting the Trust's objective to provide safe quality care. She also highlighted the increasing national focus on all aspects of patient safety.

The framework highlighted a number of principles to be followed and suggested that there were a number of specific areas of patient safety that could be addressed over the coming five years. In particular, she referred to proposed reductions in hospital standardised mortality rates (HSMR) and reductions in the number of adverse events by the use of the global trigger tool. It was noted that the approach to reductions in HSMR had provided to be very successful both within the UK and in other parts of the world. A reduction of 20% over five years was being proposed.

Caroline Langridge and Brian Rigby expressed concern that the Trust aim in this area may be unachievable and might wrongly suggest that the Trust had a problem. Elaine Strachan-Hall confirmed that the Trust mortality rates were not a cause for concern, but that the target was an aspirational target intended

to show the ORH's commitment to safety and the pursuit of excellence. Other trusts in the UK had been successful in lowering mortality and adverse events rates. James Morris said he agreed with this approach, and that there was always scope to improve.

Ken Fleming added his support for the target; visible targets with clinical leadership and Board-level focus would be successful and hence targets for improvement were important. There is evidence from around the world that such targets do make an impact. He felt it would be important to seek improvements year on year.

Caroline Langridge enquired if it was something its peer group did. James Morris advised that peer group mortality rates could be accessed on the DH website together with HSMRs for other Trusts. It was clear that this was an aspect of patient safety where there were national expectations for improvements.

The Chief Executive noted the global interest in patient safety, and agreed that a focus on hospital safety brought improvements. Elaine Strachan-Hall drew attention to the number of patient safety programmes within the framework, many of which were already underway and which she would wish the Board to endorse and support.

The Chairman thanked Elaine Strachan-Hall for the paper, adding that the Board appreciated the involvement and supported the aspirations for continued improvements in patient safety. He commended the framework and would wish to see the programmes continue. The safety walkabouts should proceed as soon as possible and Non-executive Directors be encouraged to participate.

The Board endorsed the patient safety framework and noted that further work would continue to develop specific targets for improvements. It was agreed that the Board would receive annual updates and that the Governance Committee should oversee specific aspects of the patient safety programmes.

TB 58/08 HCC cardiac review update

The HCC carried out a follow-up visit to the Trust on 6 and 7 May and it is anticipated that their final report will be available in the Autumn. The SHA has monitored delivery of the detailed action plan, and submitted assessments of our position to the HCC in April and June this year.

The Governance Committee has reviewed the current position and noted that 11 of the 13 recommendations have been

assessed by the SHA as completed, with the remaining two assessed as partially completed. The Board noted the table which included the work being done in relation both to the outstanding recommendations and to other continuing work, including the development of processes to ensure the sharing of learning. Other areas of focus included the audit of outcomes for high risk patients and the development of clinical effectiveness and audit across the Trust as a whole.

Colin Reeves recalled that Mr Ratnatunga had attended the Trust Board in July 2007 to present the cardiac surgical outcome data for the period end 31 March 2007. It was agreed that he should be invited to present outcome data for 2007/08, once the data had been properly audited and validated.

ESH

It was noted that both the SHA and the HCC were expected to sign off the action plan in the Autumn and the outcome would be brought back to the Board.

TB 59/08 Inpatient survey 2007

Elaine Strachan-Hall noted that both the HCC's Annual Inpatient survey and the Annual Complaints report provide important information on what patients are saying about their experiences of our services and facilities. Both reports showed higher levels of satisfaction than in the previous year. It was noted that the Trust is above average across many areas of the survey, but would continue to try and achieve excellence in all areas. Attention now needs to focus on how it best provides patients with better information and on how quick responses and actions can be taken to points raised by patients during or shortly after their stays/visits in hospital. In addition, it would be important to build on best practice – for example, the results on the quality of food were highest within cardiac services although the food was no different from that provided elsewhere within the JR. Clearly, the presentation and quality of service at meal times had had a positive impact on the patients and their perceptions.

Brian Rigby said he had previously raised the idea of a discharge pack containing a survey. Through such a means it might be possible for the Trust to access information much more quickly than was possible through the Annual Survey on a quarterly analysis of complaints. Elaine Strachan-Hall replied that the Trust commissions Picker to undertake the national patient surveys but that work was now underway to see how a number of feedback mechanisms might be commissioned and brought together to provide more comprehensive and timely sources of information. The Board noted that local service and

patient surveys were undertaken across the Trust and that Matrons' reports included the outcomes.

Trevor Campbell Davis added that he had spoken with Angela Coulter, Chief Executive of the Picker Institute, and that the Trust will consider conducting a pilot using electronic aids as a means of receiving immediate feedback from patients.

The Board received the report and noted that the results of the survey had been circulated to the Divisions and an action plan created, focusing on the nine lowest scoring questions.

The Board noted that progress on the action plans will be monitored quarterly by the Patient Partnership Committee and reported to the Governance Committee. The Board also noted that the HCC would carry out two surveys during 2008/09; the annual patient survey and a survey on patients' experiences in the emergency department. It was noted that the outcomes of patient surveys would be taken into account in the HCC's assessment of the Trust's performance against the new indicators.

TB 60/08 Separate gender accommodation

Elaine Strachan-Hall said that the report showed the improvements that had been made over recent months as a result of a significant amount of work across all areas. The Trust now has two additional single gender wards, higher percentages than the national average for treating patients with privacy, dignity and respect and the number of patients being placed in a mixed environment (albeit with their consent) has also fallen. Caroline Langridge enquired about a target date to eliminate the five remaining mixed wards. Elaine Strachan-Hall replied that this was problematic with regard to the variance of the changing number of male and female patients and is particularly difficult in the case of single specialty wards, and that perhaps a target would not be appropriate given the number of factors, including control of infection, that need to be taken into account. It was noted that the PCT monitors a programme for improving dignity and that compliance with the relevant core standards would be included in the regular reports to the Board.

TB 61/08 Annual Complaints Report

Elaine Strachan-Hall stated that fewer patients had complained between 1 April 2007 and 31 March 2008. The number of complaints referred for second stage investigation also reduced significantly from 34 to nine, although eight of these had been upheld by the Healthcare Commission. Work continued to

ensure close liaison with the HCC to make sure that action plans were appropriate and deliverable and that learning was shared across the services.

The Board received the Annual Complaints report for 2007/08.

TB 62/08 Infection Control work programme for 2008/09

James Morris highlighted the fact that patient safety was at the top of the Trust's key risks and that proper and active management of healthcare acquired infections and compliance with the Hygiene Code would be a major contribution to managing this risk and ensuring the continued focus on patient safety. The overall objective of the annual work programme (required for compliance with the Hygiene Code) was to ensure ownership of infection control throughout the Trust – from Board to ward and the programme was comprehensive and covered a large number of specific areas.

A member of the public asked about the programme of work around C.difficile and the process followed if samples were contaminated. James Morris replied that infection control was one of the research themes within the OxBRC, reflecting its importance. In addition, a baseline audit of antimicrobial prescribing across the Oxfordshire Health economy had been carried out in partnership with the PCT. It was agreed that he would take the points made by the member of the public into account.

JM

Ken Fleming enquired why the target for compliance on hand hygiene was 95% as opposed to 100%. James Morris replied that 100% is hard to achieve except during observed audits. However, the importance of compliance was recognised and attention would continue to be paid to compliance with this and all other infection control policies and procedures.

The same member of the public asked a question about spillage of bodily fluids. However, this was Health & Safety issue and it was duly noted. He enquired also why there was no reference to his question at the previous meeting concerning accreditation of ORH pathology laboratories in the minutes. The Chairman agreed that the minutes would be amended to reflect the points made.

JK

The Board reviewed and agreed the infection prevention and control programme for 2008/09 and noted that reports would continue to be made to the Finance & Performance Committee, the Governance Committee and the Executive Board.

TB 63/08 Improving cleanliness and infection control

Elaine Strachan-Hall presented the second report focusing on

the recruitment and role of matrons. The ORH has increased the number of matrons, meeting the required targets, and confirmed the role and accountability. Matrons have a particular role to play in monitoring the cleaning services provided by external contractors and are able to seek improvements as required, working closely with the facilities teams. Matrons were able to instigate terminal cleans. The Board did not consider the financial implications of the improvement cleaning regimes.

Matrons are now required to provide monthly reports to the Director of Nursing & Clinical Leadership to identify, inter alia, improvements in cleanliness, infection control and improvements to patient care.

An increasing awareness of the customer focus agenda has been reflected in work on the renal ward at the Churchill Hospital. The Matron has introduced random surveys to hear about the experiences of patients and then uses the information to give immediate feedback to staff. Whilst this identifies areas for further improvement, it also provides an opportunity for positive comments to staff.

It was agreed that a trial of hand-held devices and discharge packs would be explored so that more immediate feedback could be obtained on the quality of services, although it was recognised that there would be resource implications.

The Board received the report on the work of the Matrons, noting the clarification of roles and responsibilities, the outcome of both TEAR and PEAT inspections, and the work of the estates and facilities teams. It was noted that a further report would be brought to the Board on the development of the deep cleaning programme.

TB 64/08 Hygiene Code inspection and reporting

The Board received the tabled report from the Healthcare Commission following their inspection of the ORH in March 2008. The report highlighted four actions required in relation to two specific Duties within the Hygiene Code. Dr Morris confirmed that actions had already been taken in relation to the first three recommendations and that work continued to coordinate the Trust's work on decontamination and cleaning. Dr Morris stated that he had now assumed chairmanship of the ORH Decontamination Group as the Director of Infection Prevention & Control. This group would be meeting later in the day.

The Board received the report and noted that the actions were to be completed within six months. It was noted that a report

would be submitted to the SHA on the position to date as the SHA would be monitoring the ORH on behalf of the HCC.

TB 65/08 Board Committee minutes

▪ **Audit Committee 12 June 2008**

Colin Reeves reported that the meeting had considered the Annual Accounts 2007/08, the CEAC Annual Report and Head of Internal Audit Opinion, and agreed to recommend the accounts to the Trust Board being held later that afternoon. It had also recommended that the Annual Accounts be accompanied by the Annual Report in future.

▪ **Governance Committee 25 June 2008**

Ken Fleming noted that discussion on the Annual Health Check had covered identifying a resource to support the programme, and wondered if the support was in place. It was agreed that Divisional Quality and Risk Reports should be more focused, to show the current position and progress.

TB 66/08 Consultant appointments, sealings and publications report

Noted.

Any other business

None.

Date of the next meeting to be held in public

Thursday 18 September at 11 am in the Stable Block Committee Rooms at the John Radcliffe Hospital.