

**CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST**

Minutes of the meeting of **CUH'S BOARD OF DIRECTORS** held on Tuesday 28 April 2009 at 08.30 in the Boardroom, Addenbrooke's Hospital.

**PRESENT:** Dr M Archer (Chairman)  
Dr G Goodier  
Dr J Ahluwalia  
Prof M Bobrow  
Dr K Castille  
Mrs F Cousins  
Mr G Coteman  
Mr S Graves  
Mr C Greenhalgh  
Mrs S Johnstone  
Mr D Jones  
Mr J Potter  
Prof J G P Sissons  
Mr D Smith

**IN ATTENDANCE:** Dr A Alderton (Trust Secretary)  
Mr C Black  
Mrs B Hennessy  
Mr R Howe  
Mrs R St John Murphy  
Mrs J Walters  
Ms E Taylor (Board Secretary)

For certain items:

Mr G Pascoe (for Item 5.1)  
Mr J Ghosh (for Item 5.2)

There were no apologies.

Action & Target Date

**84/09 MINUTES OF THE PREVIOUS MEETING**

The minutes were agreed as a correct record.

**85/09 MATTERS ARISING FROM THE MINUTES**

**(A) PATIENT SAFETY AND SUIS**

The Executive Medical Director reported on Serious Untoward Incidents that had taken place since the last Board meeting.

Noted

1. the Board was briefed on the status of the investigation into the use of a non-sterile procedure for the tongue-tie surgical procedure.

The Board expressed its gratitude to the phlebotomy team and the Patient Advice and Liaison Service team which had responded to the incident, and its concern for all necessary action to be taken to prevent any possible future recurrence of the incident.

2. [Paragraphs removed under Sections 40 and 36 of the FOI Act.]

**(B) INTERNAL COMMUNICATIONS AROUND PATIENT SAFETY**

The Chairman reported.

Noted

- (i) The Chairman had met together with the Director of Communications, the Chief Nurse and Operating Officer and the Executive Medical Director to discuss the best means by which to convey the level of priority attributed by the Board to patient safety. The following statement had been agreed:

“Patient safety is at the heart of all we do and it is an explicit priority for the Board of Directors”.

This statement would be integrated into the Trust’s ‘Our Way’ literature and rolled out to staff throughout the organisation, through strong leadership by managers and by clearly integrating the message into staff training material, as well as through communicating the message via the website and the press.

RM / ALL

**(C) IMPROVING BOARD EFFECTIVENESS**

The Chairman reported.

Noted

- (i) A report on ‘Improving Board Effectiveness’ would be considered by the Board at its Away Day on 22 June 2009. The report was being authored by the consultancy firm, Independent Audit, following its recent research into the work of the Board.
- (ii) The Terms of Reference for the Audit Committee, the Clinical and Corporate Governance Committee and the Finance, Operations and Performance Committee had been revised. Subsequent comments by Directors had been received and noted by the Trust Secretary.
- (iii) FOPC would move towards a pattern of monthly meetings from May 2009 onwards and would be chaired by the Chief Executive. Meetings would take place in the week prior to monthly meetings of the ‘core Board’ (Executive and Non-Executive Directors). FOPC would also convene in each August and December, and a Deputy Chair would be appointed.
- (iv) CCGC would be renamed the ‘Quality and Risk Committee’. The final details would be confirmed with the Committee Chairman. This Committee was also reviewing its range of reporting committees.
- (v) Membership of the Audit Committee and increasing the involvement of Non-Executive Directors was being considered. Independent Audit had suggested that the Board consider incorporating external membership into the committee. The NHS Act 2006 precluded the Trust from being able to do this, although it may be possible for an external member to sit in attendance and to fully participate in its work. Members recognised that any such arrangements would require a code of conduct and terms of confidentiality to be made clear. With regard to increasing involvement of NEDs in the Audit Committee, it was suggested that the core membership be expanded by 1-2 additional NEDs and that any NED could attend should they wish to.

- (vi) Frances Cousins, Executive Director of Information Systems and Analysis, would succeed Jim Potter, Non-Executive Director, as Chairman of the IT Programme Board. Brenda Hennessy, Director of Patient Experience and Public Engagement, would succeed Shona Johnstone, Non-Executive Director, as Chair of the Patient Experience Committee (PEC).
- (vii) The concept of operating a 'Greater Board' and a 'Core Board' of voting Directors (Executive Directors and Non-Executive Directors) had been suggested by Independent Audit. The Chairman proposed moving towards this system with effect from the next meeting to be held 26 May 2009. It was proposed that the core Board would meet monthly and that the whole Board would meet quarterly, at the end of each quarter. The next meeting of the whole Board would therefore be on 28 July 2009 (followed by October 2009 and January, April and July 2010). The dates would be circulated in due course. The Trust and Board Secretary would revise the Business Calendar together with the Chairman to ensure that items were reviewed at appropriate meetings.
- (viii) Professor Bobrow noted that the Human Tissue Committee was essentially an Executive Committee which should not be chaired by a Non-Executive Director. The same question was to be raised in relation to all of the committees reporting to the Quality and Risk Committee.

## 86/09 FINANCIAL PERFORMANCE REPORT

Received the report of the Executive Director of Finance for the period to 31 March, as copy attached to the minute book.

The Chairman of FOPC, reported.

### Noted

- (i) The end-of-year outturn had been as predicted. The discussions at FOPC had highlighted some of the good work that had been done to improve the Trust's financial position for the year, but had also drawn attention to an element of missed opportunities with regard to strengthening the Income and Expenditure margin, rebuilding EBITDA and understanding the role of Effective Patient Care and the NHPPD.
- (ii) With regard to 2009/10, it was important to focus on what would matter most to the organisation. It was possible that in 2-3 years' time the Trust could be approaching a challenging financial period which could be very difficult to cope with.
- (iii) It would be valuable to improve capital tracking and capital forecasting. Bi-monthly meetings were held by a small team of Executive Directors to discuss the capital programme. These discussions could take place at FOPC.
- (iv) The Pay Authority Panel had been disbanded in serving substantive staff. Divisions now had the budget in place to oversee pay concerns internally and would only need to escalate concerns in relation to a budgetary over-spend or as a result of Agenda for Change queries.
- (v) Members discussed the role of bank staff in managing patients who may require 1-1 nursing. The most recent data showed that bank staff had been reduced. However, the Chief Nurse and Operating Officer would not recommend a significant reduction in bank staff.

- (vi) The FOPC had sought to further integrate Operations and Finance discussions. It was felt that, increasingly, the issues were now being understood in context.
- (vii) A pilot scheme to reduce nursing bank shifts was being tested. This involved the rostering of specialist nurses across other areas for one shift per week. This would bring significant savings to the Trust should it be rolled out more widely. Members cautioned, however, that the rationale behind doing this had not necessarily been made clear to the nurses. Consultants were also reluctant to lose nurses from their specialist area.
- (viii) The Finance Department was analysing the relationship between staff pay costs, headcount and WTE figures and would present its findings as part of the Month 1 Financial Performance Report.
- (ix) It was important to move to prospective financial forecasting and to encourage divisions to do this with regard to their expected year-end position to enable the Trust to more accurately forecast its total year-end position. Historically, there had been a lag of £15M with regard to capital expenditure. This situation had been redressed. A lag of £3.6M had been built into the Plan for 2009/10 in order to take account of Financial Risk Rating criteria.
- (x) There were lessons to be learned in relation to capital control and the control of cash. Investment in the N-wards reflected the decision to prioritise quality care although funds had not been available in the capital programme.
- (xi) [Paragraph removed under Section 36 of the FOI Act.]

Agreed

Capital planning and spend would be reported to FOPC on a bi-monthly basis.

**SG**  
**Time-scale**  
**ongoing**

**87/09 COMMISSIONING UPDATE**

The Director of Commissioning reported.

Noted

- (i) Since the previous meeting on 31 March, the PCT had retracted its 2009/10 contract. The details of the agreement had been re-visited and had resulted in a slightly renegotiated position which benefited the Trust an additional £100K.
- (ii) The PCT had queried the original contract based on the perceived level of associated risk. The level of associated risk to the PCT appears to have remained the same.
- (iii) The new contract was due to be signed within the next few days. Until then, the Trust would continue to operate under the existing contract.
- (iv) Future meetings of the Contract Management Board would be chaired by the Chief Executive of the PCT, who was due to succeed the Chair of the PCT in overseeing its work. This would then operate as an Executive Committee.

Agreed

The Board joined the Chairman in thanking Mr Black for his work.

**88/09 RISK-ASSESSED INTEGRATED BUSINESS PLAN (2009/10 BUDGET)**

Received the 2009/10 Budget as copy attached to the minute book.

The Executive Director of Finance reported.

Noted

- (i) Capacity planning was a key risk area that the Board needed to focus on. Good progress had been made during the past month with regard to winter planning for 2009/10.
- (ii) The delivery of divisional Cost Improvement Plans (CIPs) had been risk-assessed and was rated as high-risk for Medicine since it relied on a 10% reduction in average Length of Stay. The Divisional Director for Medicine, had been invited to the next meeting of FOPC to discuss the associated risks in greater detail. The delivery of the CIP for Investigative Sciences was also highlighted as a risk since this depended upon Trust-wide reduction of demand and on an effective cross-charging system. The Surgical Division was confident its CIP could be delivered, conditional upon the protection of surgical beds.
- (iii) [Paragraph removed under Section 36 of the FOI Act.]
- (iv) It was possible that some transitional relief would be received through additional Research and Development funding but details had not yet been confirmed. The Financial Risk Rating (FRR) was set to increase from 3 to 4 for years 2 and 3 if the surplus reached at least £7M. Members asked whether there were any further known efficiency savings that would be fundamental to achieving an FRR of 4, and whether risk-assessment had also been carried out on these factors.
- (v) The Board advised that Monitor should be informed at an early stage, ahead of the Trust's formal submission of its 2009/10 plan, about the variation from the 2008/09 plan. It was important to present a coherent and well-evidenced strategy that reflected the divisionally-led nature of the delivery of the annual plan and the Board's awareness of the different associated risks per division.
- (vi) The Board recognised the substantial pressures on the A&E target.
- (vii) It was understood that the Trust's participation in Cambridge University Health Partners depended upon maintaining a minimum Financial Risk Rating of 3.

Agreed

- (i) Progress on CIPs would be monitored divisionally and by the FOPC. Special attention would be paid to the delivery of the agreed CIP for Medicine.
- (ii) The Board would give a clear and balanced account to Monitor of the events of the past year which had led to a deviation from the 2008/09 business plan, the lessons learned, and the controls and measures in place for the delivery of the 2009/10 plan. Discussion should take place in a formal setting.
- (iii) It was useful to view the agreed minimum surplus for 2009/10 (of £1M)

as a pivotal step in the journey towards the level of surplus for years 2 and 3 which would be required to regain an FRR of 4.

## 89/09 INFECTION CONTROL

### (A) Infection Control Performance Report

Received the Infection Control Performance report to 31 March 2009, as copy attached to the minute book.

The Executive Medical Director reported.

#### Noted

- (i) There had been 29 cases of MRSA bacteraemia during 2008/09, against a ceiling of 33 cases, and 294 cases of *C. difficile*, against a ceiling of 300 cases.
- (ii) During March 2009, there had been four cases of MRSA and 22 cases of *C. difficile*.
- (iii) [Paragraph removed under Section 36 of the FOI Act.]
- (iv) During the year, 10 MRSA bacteraemia had occurred pre-48 hours of admission. Overall, there had been 14 cases post-48 hours, if the five contaminants were excluded. Four years ago, there had been 121 cases.
- (v) Isolation times for cases of *C. difficile* remained under pressure. It was anticipated that potential cases of H1N1 Influenza A (swine flu) could also impact on the availability of side-rooms.
- (vi) The Infectious Diseases team had agreed daily review of all patients with *C. difficile*. The hours for the central venous line team had been extended.

#### Agreed

- (i) The Chief Executive led the Board in thanking the Executive Medical Director and all staff involved in bringing about a sustained and marked improvement in infection control during 2008/09. It was important to continue to reduce rates of infection year-on-year; the Board recognised the efforts of staff in doing so.
- (ii) Future infection control reports would be received monthly, with a quarterly in-depth discussion. Reports would also display data at the divisional level.

### (B) H1N1 Influenza A

The Executive Medical Director reported.

#### Noted

- (i) The Director General of the World Health Organisation (WHO) and the Health Protection Authority (HPA) had moved the state of alert for the H1N1 virus to Phase 4, which indicated that the stage of sustained human-to-human transmission had been reached. At the global level, the focus of advice was around mitigation and preparation. At present in

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the UK, there were two confirmed cases in Scotland.

- (ii) Tom Bennett, Director of Operations, was leading the contingency measures being put into place for the management of pandemic flu. The Communications Department was fully involved.
- (iii) It was possible that some contingency funds would need to be released to provide additional support for major incident contingency planning.
- (iv) It was expected that there would be a great deal of public interest in this issue and Freedom of Information enquiries about related correspondence. It would therefore be useful for discussion of Trust actions to be made readily available to the public. The Executive Medical Director would alert Tom Bennett to this.

Agreed

Should the situation escalate, the Trust would work in partnership with the Strategic Health Authority in order to convey the right message to the public.

RM Time-scale: As required
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**90/09 OPERATIONS REPORT (including recommended actions for capacity planning)**

Received the Operations Performance Report to 31 March 2009.

Noted

- (i) Capacity planning had been discussed at the FOPC and by the executive on a daily basis. Activity forecasts showed that the Trust could be short of 43 beds over the winter. A number of short-term options had been considered. The achievement of the 10% reduction in Length of Stay for Medicine would be fundamental to the delivery of sufficient capacity over the winter. Non-elective LoS would be reduced through stringent project management for each specialty.
- (ii) It would be necessary to maintain a decontamination ward over the winter period, to support the deep clean programme that started in July 2008.
- (iii) Some interim capacity would be opened during the next few months.
- (iv) It was important to be able demonstrate to Monitor comprehensive capacity plans and the means to deliver reduced LoS in Medicine. One of the issues to address in Medicine was the component of concurrent work with regard to homecare, particularly in terms of care of the elderly. This work was ongoing and a monthly meeting was being held with the PCT.
- (v) Capacity planning included consideration of moving to seven-day services to respond to the increased demand for bed capacity. It would be necessary to discuss proposals for an economical means of delivering this. Some clinics had already extended their hours out of necessity.
- (vi) The strategy around re-admissions would be multi-factorial and would be reflected in the Quality Accounts. On average, there were one or two patient referrals by NHS Direct each week.

Agreed

- (i) The Board wished to hear details of the contingency plans in place for

JA/ Dirs of Operations Time-
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scale: <b>TBC</b>
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Medicine should the 10% reduction in Length of Stay target not be reached.

- (ii) The planned position for Years 2 and 3 should be kept clearly in mind. If Hinchingbrooke was to be a medium-term solution for achieving this it was important to engage with this early on.

## 91/09 QUALITY ACCOUNTS – PROGRESS REPORT AND UPDATE

Received the report of the Director of Operations.

### Noted

- (i) Plans were underway to bring together quality indicators across different the areas of Trust activity. The Board was due to attend a workshop led by McKinsey on 30 April to discuss linking indicators with the patient safety priorities identified in November. Quality Accounts needed to be produced within the next week. Submissions from eight pilot sites, of which the Trust was one, would be submitted by 18 May. Monitor also required a component on 2008/09 Quality Accounts to be included in the Trust's Annual Report.
- (ii) Suggested quality metrics included the C-section rate in maternity services and time to CT scans for Stroke patients. Patient Reported Outcome Measures (PROMs) would also be incorporated into the quality metrics. (PROMs were currently collected in relation to four surgical procedures.) This would give patients the opportunity to say what was important to them.
- (iii) It would be difficult to include reporting on Serious Untoward Incidents (SUI) in the Quality Accounts, given the wide range of reporting methodologies across the Strategic Health Authorities. It would be useful to include specific indicators in the area of medication errors.
- (iv) Some members expressed uncertainty as to whether the indicator around staff willingness to recommend the Trust's services to friends and family should be used.

### Agreed

It would be helpful to keep indicators 'high-level' and to ensure that these were sufficiently cross-cutting. Additional use of specialty-specific indicators would be formative of patient safety outcome measures at the divisional level. Two core objectives would be for 10% improvement in patient safety and to aim for upper decile performance in clinical effectiveness. As Quality Accounts were just being introduced at the national level, this was a key opportunity to contribute towards the national thinking going forward. Since this was a public domain document, the level of detail would also need to be commensurate with explanation.

## 92/09 DIVISIONAL DIRECTOR FEEDBACK ON THE SOUTH CAMPUS PRIORITISATION MODEL

Received a tabled paper summarising outcomes of discussion on 23 April 2009.

The Executive Director of Corporate Development reported.

### Noted

- (i) Several directors, including some Non-Executive Directors, had attended the meeting of the Joint Corporate and Clinical Executive held on 23 April 2009.
- (ii) Information had been shared with divisional directors and a wider summary of the South Campus prioritisation model had been given by the Project Director. No additional information had been made available that had not already been seen by the Board.
- (iii) In brief, it was expected that combined major capital schemes in the order of £300-400m would be very difficult to launch. It was therefore possible that only one to three schemes would go forward. It was also unlikely that construction would be completed in less than seven years.
- (iv) One of the challenges for the Board was to assess the optimum balance between capital planning for research and planning to meet capacity demands. It was important for these to dovetail as far as possible, as part of the shift towards a greater focus on translational medicine, i.e. assessment of research intersection with service delivery was needed to inform capital planning processes.
- (v) It was expected that Long-Term Conditions (LTCs) would continue to place increased demands on capacity.
- (vi) It was recognised that the prioritisation model used was sensitive to being flexed according to the weightings or value attributed to different needs (e.g. clinical needs; research priorities; usefulness of vacated space). It was understood, however, that reasonable flexing of the model did not fundamentally alter the prioritisation ranking of the Strategic Outline Cases.
- (vii) Recent discussion had highlighted the need to focus on medium-term solutions or 'phased solutions' rather than on shorter-term 'interim' solutions. Ensuring high-quality medium-term solutions was essential. If one SOC or new building was prioritised, then as a consequence all other schemes would require phased investment to meet their identified clinical and research needs.
- (viii) Members requested a transparent process around how vacated space would be used and how the decisions around its use would be taken.
- (ix) Strategically, it was important to avoid falling into the potential trap of spending all that could be afforded on interim solutions to the point where this precluded the possibility of any substantial investments. It was also unlikely that the next stage of working through the detail of the reutilisation of space would deliver clear answers in terms of clinical imperatives. Rather, the Trust would need to make its decision based on the way in which overarching priorities, in particular around capacity and DOSA, would play out in the detail of each scheme. Prioritisation therefore needed to take place in relation to the broad, over-arching pressures on the Trust as a whole. There were additional considerations around capital donations and broader regional strategy. These had already been factored into the prioritisation model but there was still scope to flex these considerations.
- (x) Monitor's rules around the Prudential Borrowing Limit were likely to change. The Treasury may constrain available funds through a series of measures. In the long run, performance assumptions around profitability would be a fundamental part of demonstrating that the surplus would be sufficient to subsidise investment.

- (xi) It was argued that solutions for A&E would do little to address capacity; essentially, investment in A&E was about improving patient safety and clinical care rather than about capacity.
- (xii) Cambridge University Health Partners, AHSC, was to be consulted on all key appointments and on capital planning, so these issues should be raised for formal discussion in the CUHP Board.

Agreed

The Board was content to review the recommendations as tabled, as to which schemes should be prioritised and how these should be taken forwards. The Board would maintain its commitment to the Perinatal Scheme. Among the remaining SOCs, Children's, Neurosciences and the Emergency Department were prioritised. Other schemes would be taken further through phased investment.

**SG  
Time-  
scale:  
Early June  
09**

**93/09 FINAL HEALTHCARE COMMISSION DECLARATION**

Received the Final Healthcare Commission (Care Quality Commission) Declaration.

Mr Pascoe, Head of Risk and Patient Safety, reported.

Noted

Mr Pascoe had discussed the declaration at the Audit Committee and had subsequently met with three Non-Executive Directors, Mr Potter, Mr Coteman and Mr Greenhalgh. Comments had been received from the Overview and Scrutiny Committee and the Children's Board. This was a final sign-off procedure to acknowledge that the Declaration had been through due process.

**94/09 QUARTER FOUR GOVERNANCE DECLARATION TO MONITOR**

Received the Quarter Four Governance Declaration to Monitor.

Mr Ghosh, Head of Performance Intelligence, reported.

Noted

- (i) Two targets had been breached during Quarter 4 and corrective action plans were in place to address these.
- (ii) Monitor had altered its methodology around the reporting of Thrombolysis so that small numbers would now not come into play. The Trust had always achieved the percentage target so was not at risk going forward.
- (iii) The escalation process had been triggered in relation to the A&E target which had been breached in Quarters 2 and 4 during 2008/09. The escalation process was overseen by Monitor and meant that the Trust was being more closely monitored against this target and required an action plan to rectify the situation. A regulatory meeting with Monitor would need to be attended should another breach occur during the next four quarters. The context of the A&E breaches would be discussed with Monitor. There was a strong likelihood of a further breach of the A&E target in Quarter 4 of 2009/10.

Agreed

Action & Target Date
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The Board wished discussion of A&E with Monitor to take place in conjunction with discussion of the Annual Plan for 2009/10.

GG/ DS ASAP
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**95/09 NOMINATION OF CUH ACADEMIC LEAD TO THE CUHP BOARD**

The Regius reported.

Noted

- (i) Cambridge University Health Partners did not yet formally exist, although the intention was that it should be established as a legal entity by the summer. The first meeting of the proposed CUHP Board was due to take place at the end of May and would be chaired by Sir Keith Peter as Foundation Chair. The three Foundation Trust partners would each nominate a clinical academic member to the Board, in agreement with the University.
- (ii) The composition of the executive group to function under the outlined structure had yet to be finalised and would require the approval of the Board at its inaugural meeting. It was anticipated that the three medical directors would sit on the Board together with three clinical academic health nominees. Each member would lead on one of the AHSC workstreams.
- (iii) [Paragraphs removed under Section 41 of the FOI Act.]

**96/09 QUARTERLY UPDATE FROM THE CLINICAL SCHOOL**

The Regius reported.

Noted

- (i) As a result of the national research assessment findings it was expected that more research funding would be made available to the University.
- (ii) Two newly refurbished buildings were set to re-open, which would provide wet-lab space.
- (iii) There had recently been two new appointments: [Section removed under Section 41 of the FOI Act.]
- (iv) [Paragraph removed under Section 43 of the FOI Act.]
- (v) A Board meeting of Cambridge University Health Partners was due to be held at the end of May. A Chief Operating Officer had been appointed.

Agreed

- (i) The outcomes of the meetings of CUHP would be noted as a standing item for information.
- (ii) The Board would like to see the report from the Dean of North-Western University, Chicago.

PS Time-scale: 26 May
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**97/09 COMMUNICATIONS REPORT MARCH 2009**

Received the Communications report for March 2009.

Noted

- (i) In the near future, BBC1 was due to produce a popular science documentary about death. Consultants from NCCU, the ICU and the ED were involved in discussions that could lead to four months of filming and a programme based at the Trust costing £250K. The Trust would receive dividends plus the opportunity to promote its activity.
- (ii) Channel 4 and the Wellcome Trust were working on a project to broadcast surgery live on television. Four programmes were expected to go on air at the end of May. Full consideration would be given to patient safety as well as to related reputational risks, prior to agreement to go ahead with the filming. The essential ethical issue was around patient consent, which had been sought. The benefit of live, as opposed to pre-recorded, surgery lay with higher viewing figures. Alternative footage would be available for all four programmes.

**The Director of Communications to circulate the note of agreements with the production team.**

**RM  
ASAP**

**98/09 MINUTES OF REPORTING COMMITTEES**

Received and noted the following minutes of reporting committees along with a corresponding summary highlighting emerging issues against the Risk Register.

**Governor/Director Working Group – Forward Planning – 19 March 2009**

**Governor/Director Working Group – Governance and Assurance – 30 March 2009**

**Losses and Compensations Panel – 2 April 2009**

**99/09 BOARD AWAY DAY NOTES – 23 FEBRUARY 2009**

Received and noted.

**100/09 REPORT OF THE CHAIRMAN**

Received the report of the Chairman, as copy attached to the minute book.  
Noted

On 13 May the Duke of Kent was due to visit the Trust at the invitation of Dr Tim Wreghitt, Health Protection Authority. It was hoped that there would be an opportunity to discuss corporate issues.

**101/09 REPORT OF THE CHIEF EXECUTIVE**

Received the report of the Chief Executive, as copy attached to the minute book.

[Section removed under Section 43 of the FOI Act.]

**102/09 MEDICAL AND DENTAL SUSPENSIONS**

Action & Target Date

There was nothing to report.

**103/09 SEALING OF DOCUMENTS**

Items 110-122 were noted in the register.

**104/09 CHAIRMAN'S ACTIONS**

There was nothing to report.

**105/09 DATE OF NEXT MEETING OF THE CORE BOARD**

**Tuesday 26 May 2009**

**106/09 ANY OTHER BUSINESS**

Noted

The Chairman of the Audit Committee had raised the issue of the Gateway Review Process in the Agenda for Change pay bands at the previous meeting. At the recent Audit Committee meeting members had reviewed findings from a follow-up review which had shown a range of original recommendations and actions were still be implemented. An internal audit based on a small sample of employees had shown that 80% of staff had not yet received review prior to their incremental date. It seemed that this could be a greater issue than initially been assumed. The Audit Committee was satisfied that this was high on the Trust's agenda and that action plans were now underway, which included increasing the support for managers in using the Key Skills Framework and improved communications around staff appraisal due dates. As a result, it was expected that positive change would be brought about in relation to performance management, staff behaviour and accountability.