NHS
Mid and South Essex
University Hospitals Group

Trust Boards Meeting in Common – SESSION IN PUBLIC

Minutes of a meeting in public of the Trust Boards in Common held in common at 2.00pm on Wednesday 15th January 2020, at Saxon Hall, Aviation Way, Southend on Sea, Essex

Present

BTUH Board (non-executive members)

Nigel Beverley	Trust Chairman and Presider over this meeting
Lynsey Cross	Non-Executive Director
Renata Drinkwater	Non-Executive Director
Margaret Pratt	Non-Executive Director
Barbara Stuttle	Non-Executive Director

MEHT Board (non-executive members)

Alan Tobias	Trust Chairman
Colin Grannell	Non-Executive Director
Karen Hunter	Non-Executive Director
Jill Stoddart	Non-Executive Director
David Wilde	Non-Executive Director

SUHT Board (non-executive member)

Alan Tobias	Trust Chairman
Mike Green	Non-Executive Director
Tony Le Masurier	Non-Executive Director
David Parkins	Non-Executive Director and Deputy Chair
Gail Partridge	Non-Executive Director
Gaby Rydings	Non-Executive Director

Tim Young	Non-Executive Director
Executive Team	
Tom Abell	Deputy Chief Executive / Chief Strategy and Transformation Officer
Yvonne Blucher	Managing Director, SUHT
Martin Callingham	Chief Information Officer
Jonathan Dunk	Chief Commercial Officer
Jane Farrell	Managing Director, MEHT
Danny Hariram	Chief People and OD Officer
Eamon Malone	Chief Estates and Facilities Officer
Clare Panniker	Chief Executive
Andrew Pike	Managing Director, BTUH
Diane Sarkar	Chief Nursing and Quality Officer
David Walker	Chief Medical Officer
In attendance	
Amanda Burton	Head of Communications, SUHT
Ron Capes	Lead Governor, BTUH
Les Catley	Lead Governor, SUHT
Charles Curtis	Public Governor, BTUH
James Day	Trust Secretary and Director of Strategy, MEHT
Julia Harding	Public Governor, BTUH
Fran Haysom	Public Governor, SUHT
Matron Kelly Moore	Matron/Clinical Lead, Home Therapies Team (for item 9)
Sister Georgie Pharro	Home Therapies Team (for item 9)
Brinda Sittapah	Company Secretary, SUHT
Andrew Stride	Group Director – Corporate Governance Integration (minutes)
Brian Terry	Public Governor, SUHT
3 members of the public	

1. Welcome, opening remarks and apologies for absence

1.1. With agreement from all present, Nigel Beverley presided over this meeting.

1.2. Apologies were received from Fred Heddell (Non-Executive Director, SUHT).

1.3. The Trust Chairs confirmed that each of the Trust Boards meeting in common were quorate.

2. Declarations of interest

2.1. All present declared an interest in respect of their substantive roles as Board members of one or more of the MSE trusts.

3. Minutes of the previous meeting held on 13th November 2019

3.1. The Boards in Common reviewed the draft minutes of their previous meeting. The following amendments were agreed:

- Paragraph 10.1 – typographical error on the first line "present";
- Paragraph 13.3 – typographic error final line "die-due";
- Paragraph 14.4 – a line to be added to the end of this paragraph to the effect that Tom Abell informed the Boards that a new system had been introduced whereby family and carers could obtain scratch cards or bus tickets to help overcome the additional inconvenience from the relocation of some services.
- Paragraph 17.3 – typographical error in the third line "Southend Hospital".

DECISION

The Trust Boards of MEHT, SUHT and BTUH approved the minutes of their meeting in public held on 13th November 2019 subject to the amendments noted above.

4. Matters arising and action log review

4.1. Members reviewed the action log and agreed the following:

- *Action BIC 13.11.19/06 (irritable bowel syndrome support group at BTUH)* – Andrew Pike confirmed that this group was still active. He agreed to circulate a note to Governors with contact details and meeting arrangements. **Action closed**.

ACTION BIC 15.01.20/01

Circulate a note to BTUH Governors regarding the IBS support group. LEAD – Andrew Pike

4.2. Members were content to close the action that was proposed for closure and agreed that the remaining actions were not yet due, as reflected in the log.

5. Risk Management and Compliance Update

5.1. Diane Sarkar provided the MSE Boards in Common with a progress report on the risk management methodology across the Group and compliance with quality, regulatory and professional standards across the MSE hospitals.

5.2. She explained that risks on the Board Assurance Framework (BAF) continued to be reviewed by the committees in common and the next formal review would be presented to the Boards in Common in March 2020, in line with the established quarterly cycle.

5.3. Diane invited colleagues to note the feedback letters from the Care Quality Commission (CQC) following recent inspections at SUHT and MEHT. These letters were appended to Diane's paper and received in public session.

5.4. Across both trusts, Diane explained, there had been significant positive feedback in relation to Core Services and the Well Led domain. Diane had fully responded to the CQC on all of the matters outlined in the letters. The CQC Team were impressed by the energy and enthusiasm amongst the Site Leadership Team at MEHT. It was also noted by the CQC that Southend Hospital had transitioned to a more stable business as usual mode of operations.

5.5. The three Quality Committee Chairs had reviewed the actions taken and were satisfied with them. The final reports for MEHT and SUHT were anticipated in late January or early February 2020.

5.6. Diane informed the Boards that there had been no change in the top risks identified by the sites since the previous governance cycle.

5.7. In response to a question from Mike Green, Diane confirmed that the CQC had carried out unannounced inspections on both sites as well as visits with ten days' notice.

5.8. Mike expressed frustration that the inspection team had noted avoidable minor operational issues such as the need for repairs to a toilet. Diane agreed, advising that the cycle of peer inspections across MSE would continue, in order to help maintain standards.

5.9. Nigel Beverley requested further assurance with regard to the increased contact to the Freedom to Speak Up Guardian from staff working in the Essex Cardiothoracic Centre (CTC) at Basildon Hospital, as noted in the report. Andrew Pike replied that the investigation report and action plan had been scrutinised through the Site Governance Forum (SGF). The investigation identified some notable concerns throughout the CTC, including the need for improved teamworking. Andrew Pike added that the SGF would receive evidence at their meeting later in January 2020 that staff felt confident in raising concerns.

5.10. Tim Young highlighted the reference in the SUHT letter that quality improvement knowledge could be stronger amongst site leaders. Diane replied that quality improvement methodology and tangible examples of its application were a significant focus for the CQC.

The key issue identified by the CQC in this regard was that although there were some references to the Plan Do Study Act (PDSA) cycle, nobody that the CQC spoke to had been able to articulate practical examples of its use.

DECISION

The Trust Boards of MEHT, SUHT and BTUH agreed

i)To note the risk management and compliance report; and

ii)To review and note the feedback letters from the CQC following inspections at SUHT and MEHT.

6. Patient Story from Southend Hospital

6.1. Yvonne Blucher introduced a pre-recorded video of a patient story relating to the cancer pathway from presentation in the Emergency Department through to diagnosis of the initial tumour site and then a brain metastasis 6 weeks later.

6.2. Building on the account given by the patient of her treatment in 2016, Yvonne highlighted the key messages including the frustration and time associated with the referral between Basildon and Southend Hospitals. There was evidence of poor communication at ward level and the patient did not feel listened to.

6.3. Yvonne concluded that the records supported the perception of the patient, that all staff at both hospitals were trying to provide her with the best care they could but there was no documentation showing appropriate standard of communication with the patient during her journey through cancer services. Yvonne added that this video was now being used as part of training for doctors and nurses, with permission of the patient.

6.4. Noting that this story related to 2016/17, David Parkins enquired as to whether the patient pathway had improved in the past three years. Yvonne assured colleagues that this was the case, citing enhanced consultant to consultant dialogue between the sites to minimise the risk of a disjointed journey for patients. She continued that the Cancer Clinical Nurse Specialists (CNS) added significant value in communication between clinicians and patients. These professionals also greatly assisted the interface between acute services, Macmillan Nursing and District Nursing Services. Yvonne confirmed that clinical records were audited as to the quality of communication on a regular basis.

6.5. Andrew Pike support Yvonne's view, adding that the pathway was now much more tightly managed than had been the case three years ago.

6.6. David Walker noted that patients often found it difficult, across all specialties and hospitals, to know who to contact in the event that they had a question or concern about their care. A single point of access, he added, would add significant value to patients and carers.

6.7. Tom Abell agreed, reminding Board members that each hospital operated a Patient Advice and Liaison Service (PALS) which was intended to act as this single point of access for such queries or feedback on clinical services. All were agreed that there was a need to further develop PALS across MSE, in terms of enhancing and standardising its role and its accessibility to patients and carers.

6.8. In response to a request from Barbara Stuttle, Yvonne agreed to audit the pathway that a hypothetical patient would follow with a similar clinical presentation to that of this particular patient in 2016/17, to provide assurance to the Trust Boards that the aforementioned improvements had been sustained.

ACTION BIC 15.01.20/02

Audit the cancer pathway in place now that the patient in the story from 2016/17 would have followed. LEAD – Yvonne Blucher

7. Report from Trust Chairs

7.1. Nigel Beverley expressed his enthusiasm and thanks for his appointment by Governors as Chair (Designate) of the proposed merged trust. Nigel commented that he was very much driven by the opportunities that the new organisation would present to improve patient experience.

7.2. Alan Tobias congratulated Nigel on his appointment. He briefly outlined discussions at the recent SGFs at MEHT and SUHT, which focussed on exceptions within the integrated performance report (IPR). The Southend SGF also undertook a deep dive into Emergency Department performance. They had also raised a governance query regarding the relationship between the Quality Committees in Common and the Audit Committees in Common which was now being clarified.

7.3. Alan drew attention to the robust work undertaken by the MEHT Site Leadership Team on winter preparations.

8. Chief Executive's Report

8.1. Clare Panniker presented a summary of key aspects of the business of the MSE trusts in recent months.

8.2. Clare highlighted the level of patient demand in December 2019 and January 2020 which made it difficult to consistently achieve the access standards set out in the NHS Constitution for both elective and emergency care. She commended, however, the significantly improved system-wide working and co-ordination across the Mid and South Essex health and care economy compared to previous years, citing ambulance handover times as an example of this.

8.3. She explained that whilst performance against access standards over winter to date was disappointing, this was a consistent picture across the country. Clare thanked staff across MSE for maintaining their prime focus upon patient safety during periods of such high demand.

8.4. Clare informed the Boards in Common that the Group had received some central funding to help to reduce the backlog of elective cases associated with winter pressures.

9. Reflections on Practice – Renal Home Therapies

9.1. The Boards in Common welcomed Kelly Moore and Georgie Pharro to provide a reflections on practice presentation on Renal Home Therapies. As well as a slide presentation, Kelly and Georgie also gave a practical demonstration of their work.

9.2. Kelly and Georgie outlined what services were offered within Home Therapies (including peritoneal dialysis, home haemodialysis, pre-dialysis counselling, and end of life support and, in the future, conservative care).

9.3. Board members were briefed on the benefits of choosing home dialysis, including improved patient outcomes, greater freedom for patients to go about their daily lives and greater levels of compliance with treatment associated with patients managing their own dialysis. Ultimately, Kelly and George explained, this service improved the quality of life for patients.

9.4. Diane Sarkar enquired as to the degree of patient involvement in the service. It was explained that there was a well-established patient group who were regularly invited on site to give their feedback and to help identify opportunities for improvement, in partnership with clinical staff.

9.5. Tony Le Masurier asked whether there were greater risk to patients associated with dialysis by self-care at home compared to the traditional hospital-based model. Georgie and Kelly acknowledged that there were some risks such as the scope for needles placed in arteries to become dislodged. They added that home dialysis patients were required to have a carer with them at all times during treatment. The Team would provide urgent interventions if needed.

9.6. Barbara Stuttle commended the innovative nature of the home dialysis model for patients and for the skills development of staff. In terms of limitations to the service, these included the size and configuration of patient homes that could make installation of the necessary equipment problematic. The Team also liaised closely with Social Care colleagues to ensure that each patient was holistically suitable for home dialysis.

9.7. Drawing on the theme of communication and clinical pathways that underpinned the patient story, Gail Partridge requested clarity as to how the Home Therapies Team ensured effective communications for patients whose care involved multiple hospitals and community

services. Kelly and Georgie replied that the mitigations were tailored to each patient's circumstances through ongoing contact with primary and community care.

9.8. Turning to the contribution of the Home Therapies Team to end of life care, Kelly and Georgie explained that they worked closely with palliative care and pain management teams to help patients make an informed choice about dialysis.

9.9. In response to a further question from Gail, the Team confirmed that they currently used a combination of paper-based and electronic records, noting that this remained a work in progress.

9.10. Tim Young asked about the number of patients that the Team could care for at any one time. Kelly and Georgie replied that the only rate limiting step was the capacity of nursing staff rather than equipment. They continued that steps were being taken to maximise the efficiency of clinical staff including the increasing use of electronic communications to minimise the need for home visits to solve clinically straightforward problems.

9.11. Mike Green noted that Renal Home Therapies attracted a higher tariff as it was classed as specialist commissioning, highlighting the opportunity to increase income for the trusts given that the service made a surplus on the tariff.

10. <u>MSE Culture Change Plan</u>

10.1. Danny Hariram presented the draft Culture Change Plan for the proposed merged trust. He explained that this was an important stage in establishing a standardised culture across MSE. Danny continued that significant progress had been made over the past three years in breaking down the barriers to aligning cultures across the sites.

10.2. Members reflected on two recent Board Seminars on the NHSI Compassionate Leadership Programme, tailored to MSE, which underpinned the proposed Culture Plan. All were clear that Compassionate Leadership was a means to improving outcomes for patients and it was evidence-based. Members noted the high level action and communications programme as an appendix to the Culture Plan.

10.3. Danny outlined the proposal to establish an Organisational Development (OD) Programme Board that would bring together various units across MSE including OD, Communications, Strategy, senior management and clinicians. It was proposed that the Programme Board would be chaired by the Chief Medical Officer to reinforce the message that MSE was clinically led. The Programme Board would report to the Chief Executive and to the People and OD Committees in Common.

10.4. In response to a question from Lynsey Cross, Danny explained that the costs of implementing the Culture Plan would be set out in the project initiation document (PID), including the clinical backfill costs and the costs of the change team's input into the programme.

10.5. Tony Le Masurier commended the strategic fit between the Culture Plan and the Compassionate Leadership Seminars. He enquired as to the overall timescale for implementing the plan. Danny replied that although there were some tangible early strands of work that would yield benefits, evidence showed that culture change took between 3 and 5 years to fully implement in a sustainable way.

10.6. David Parkins echoed Tony's view and requested clarity on the governance of benefits realisation from the Culture Plan. Danny confirmed that proposed metrics and the arrangements for benefits realisation would be set out in the PID. Clare Panniker added that it was difficult to directly attribute and quantify benefits to the culture development work. She suggested that it was helpful to consider what the consequences would be of failing to align cultures. Nonetheless there would be some metrics in the staff survey results which could be used as a proxy for the success of the programme.

10.7. Karen Hunter highlighted the learning from other change programmes in healthcare such as the Virginia Mason Programme in the United States where it had proven challenging to engage staff from all disciplines and all levels across an organisation. Danny confirmed that this issue was at the forefront thinking in developing the MSE Culture Plan. Measures to mitigate this risk included a comprehensive communications programme, and continual support for the Programme articulated by the Executive Team and senior clinicians.

10.8. Tim Young also commended the proposed MSE Culture Plan, drawing attention to the financial benefits that would accrue if staff embraced the change. He urged the OD Team to exploit opportunities to accelerate the pace of culture change in the event that there was a better and earlier response to the Programme.

10.9. Referring to paragraph 8.7, Mike Green asked whether it was essential that external funding is obtained to ensure that the programme and capability building was of sufficient scale and impact. Danny explained that although external funding would be facilitative and would add value, MSE could deliver the Culture Plan without it.

10.10. Mike Green requested that checkpoints be incorporated into the Programme to ensure that it remained on track and aligned to the evolving nature of the new organisation. Danny agreed, advising that such checkpoints would be reflected in the PID.

10.11. Colin Grannell invited colleagues to identify how non-executives and executive members of the Boards could lead the Culture Programme by example. Clare commented on the difficulty in implementing such a programme in a highly pressurised operating environment. She assured those present that there would be development activities for the Executive Team as a whole and for individuals to support them to articulate the principles and tone of Compassionate Leadership, to which all Board members were very committed.

10.12. With regard to clinical champions for the programme, Renata Drinkwater enquired as to how they would be supported and empowered. Danny confirmed that there would be training and ongoing support for clinical champions. The champions, he continued, would be the "glue" that would link all strands of the programme together.

10.13. Danny explained that the Group were seeking to have 40 change champions from across the sites and professional groups. There had already been good levels of interest from both clinical and non-clinical staff and Danny was really pleased to say that we had a new Consultant who was keen to participate in the team.

10.14. Barbara Stuttle commended the Culture Plan and considered that this would be a good investment of time and resources. Barbara was particularly supportive of measures to focus on target behaviours and the interactions between staff.

DECISION

The Trust Boards of MEHT, SUHT and BTUH agreed to actively support the MSE Culture Change Plan.

11. Change Portfolio Update

11.1. Tom Abell provided the Boards in Common with a progress report on the change portfolio across the MSE Group.

11.2. Attention was drawn to the STP Outpatients Transformation Programme which was now live. The first three specialties (gastroenterology, respiratory and colorectal cancer) were in progress. Initial engagement had taken place with key stakeholders across the STP for those specialties, current state mapping was well underway and future state design sessions had been scheduled. Tom noted particular challenges to the outpatient programme as there were some gaps in the data, such as the reasons why patients declined an appointment.

11.3. Jonathan Dunk assured the Trust Boards that he had provided a comprehensive update on the corporate support transformation programme to the recent meeting of the Finance Committees in Common. He summarised that the planned financial benefit for the remainder of 2019/20 would be delivered. The last few service consultations with staff would commence shortly and overall, the corporate support programme was now entering a phase of consolidation and stabilisation after a period of significant change.

11.4. Responding to a question from David Parkins regarding levels of demand on key individuals with the corporate support services, Jonathan acknowledged that capacity was an ongoing issue particularly given the additional workload associated with the merger preparation and assurance processes. Phase 3 of the programme, Jonathan continued, would look again at capacity to make further improvements and efficiencies in the services to reduce the strain on individuals.

12. Clinical Reconfiguration (Phase 1) Progress Report

12.1. Tom Abell provided an update on the clinical service changes approved as the first phase of clinical reconfiguration in June 2019. He reminded colleagues that these service changes were set out within the Decision Making Business Case (DMBC) approved by the Mid and South Essex CCG Joint Committee in July 2018.

12.2. Tom explained that consolidation of emergency vascular surgery at Basildon Hospital was almost complete. Spinal surgery services went live on 25th November 2019 as planned,

initially with patients being operated on jointly between Basildon and Southend. As of January 2020, Basildon consultants were now working independently in the Southend environment. Regrettably, elective lists in early January 2020 had been cancelled due to bed capacity issues. Yvonne Blucher assured members that all patients whose surgery was cancelled had been given a new date at the time of cancellation.

12.3. The relocation of ASA 1 and 2 hip and knee patients to Braintree Community Hospital went live for Basildon patients as planned from 9th December 2019. Tom advised that 22 patients to date had received hip and knee surgery at Braintree. Both patients and staff seemed satisfied with the new arrangements. No patient had yet declined to have their surgery at Braintree and to remain at their local hospital.

12.4. Tim Young enquired as to whether there had been any issues with regard to transport for patients or visitors to Braintree. Tom responded that travel arrangements had been facilitated for 3 patients so far. Each patient was given a leaflet to assist them travel options. The use of patient transport services continued to be monitored throughout the change period. Tom reminded colleagues that aftercare for orthopaedic patients operated on at Braintree would take place in their home locality. Jane Farrell commented that at present, patients needed to have their pre-assessment at Braintree but progress was being made to move to its local delivery.

12.5. Tony Le Masurier commented on the importance of evaluating the patient experience of the new clinical models compared to those formerly in place. Tom agreed, explaining that patient satisfaction was captured at every stage. The Communications Team were compiling patient stories and videographics to illustrate the benefits of the changes.

12.6. Turning to the vascular reconfiguration, David Parkins considered that the delays associated with equipment could have been foreseen and he sought assurance that appropriate lessons had been learned. Tom explained that in February 2020 there would be a post implementation review which would formally pick up these lessons so that they could be applied to future changes.

12.7. Andrew Pike added that the key learning related to the need to proactively and reactively manage the anxieties of staff and to improve communication and engagement with staff. Martin Callingham commended the value of involving clinicians in practical aspects of the reconfiguration such as the involvement of the orthopaedics surgeons in redesigning forms.

12.8. The Boards in Common commended the hard work and commitment to reach this stage in the implementation of clinical changes. They requested a formal update on phase 2 of the reconfiguration at the next meeting.

ACTION BIC 15.01.20/03

Report on Phase 2 clinical reconfiguration to be presented to the next meeting. LEAD – Tom Abell/David Walker

13. Future Organisational Form Progress Report

13.1. Jonathan Dunk advised those present that the target date for the proposed merger of the three MSE trusts remained 1st April 2020. The key transaction documents had been submitted to NHSI following their approval by the Boards in Common in December 2019.

13.2. The final phase pre-merger, Jonathan explained, centred upon the NHSI assurance process and the Reporting Accountant process which would commence in earnest in early January 2020. Jonathan highlighted likely themes that would be scrutinised closely in this phase would include financial delivery, risk management and governance, and the future operating model for the proposed merged organisation.

13.3. As a point of clarity, Clare Panniker advised that she did not sit on the interview panel for the Chair role, as incorrectly noted in the report.

14. Integrated Performance Report (IPR) – November 2019

14.1. Boards in Common members reviewed the IPR by exception, taking assurance that the report had been scrutinised in detail by the Site Governance Forums and the Committees in Common.

14.2. Andrew Pike highlighted the increasing grip on ED performance at Basildon Hospital now that winter pressures were gradually abating which was leading to improved performance against the 4 hour target. Two extra wards were opened at Basildon, he continued, which created pressures of their own but the wards did provide necessary capacity. The cancer backlog was being removed in line with the agreed trajectory.

14.3. Yvonne Blucher echoed many of Andrew's comments, such as the opening of escalation beds during winter.

14.4. With regard to Broomfield Hospital, Jane Farrell explained that the cardiology reconfiguration was starting to release capacity. The ward in Tiptree was also assisting with patient flow. The turnaround of diagnostics was discussed as were the benefits of international recruitment which were starting to materialise.

14.5. Gail Partridge noted that there had been 8 twelve-hour breaches in ED at Broomfield in the reference period. Jane assured the Boards that due process was followed in response to these breaches which were clustered together early on a Sunday morning; flow was a critical factor. A harm review had been undertaken, Jane added, concluding that no harm had resulted to patients from these breaches.

15. Reports from Committees in Common

Finance and Performance Committees in Common

15.1. Members noted and took assurance from this report.

People and Organisational Development (OD) Committees in Common

15.2. The Boards in Common noted and took assurance from this report. Barbara Stuttle (Presider over the People and OD Commitees in Common) advised that the meeting on 20th November 2019 took the form of a seminar on culture change, to which the full Boards were invited.

Quality Committees in Common

15.3. Members noted and took assurance from this report. Karen Hunter (Presider over the Quality Committees in Common) referenced the deep dive into the mortality data at MEHT, the outcome of which would be presented at the next meeting of the Committees in Common.

15.4. Karen also highlighted the pattern of never events at Basildon Hospital. A root cause analysis was happening in every case and there was a cascade of immediate learning. She added that no harm to patients had yet been identified arising from these never events.

15.5. Board members were informed of concerns discussed at the Committees in Common about paediatric mental health support in ED. This was understood as a national issue which the Boards should continue to highlight. Alan Tobias agreed, adding that paediatric mental health services in ED had been raised at the recent meeting of the STP Chairs. The Chair of the Mental Health Trust (EPUT) would be leading on taking this important matter forward within the STP.

ACTION BIC 15.01.20/04

Report back to the MSE Boards in Common about progress on improving paediatric mental health support in ED as discussed at the STP Chairs meetings. LEAD – Alan Tobias

16. Questions and comments from Governors, Patient Council members and the public

16.1. No questions or comments were raised from the public gallery.

17. Any other business

17.1. No items of other business were raised.

18. Review of the meeting

18.1. Members were invited to reflect on the conduct and content of today's meeting.

18.2. The quality of the papers was commended, as was the timely nature of their being issued to members.

18.3. Colleagues were satisfied that they had debated high impact issues with a good degree of challenge, particularly in relation to the Culture Change Plan.

18.4. The patient story item was considered to be powerful and all were clear that it needed to be followed up as per the actions in section 6 of these minutes. It was further agreed that a brief paper would be presented to the next meeting setting out the mechanism for following up patient stories and assuring Board members of how the learning from these cases had been applied.

ACTION BIC 15.01.20/05

Present a paper to the next meeting setting out the mechanism for following up patient stories and assuring Board members of how the learning from these cases had been applied. LEAD – Diane Sarkar

19. Motion

19.1. Board members passed the following resolution:

"That representatives of the press and other members of the public be excluded from this part of the meeting having regards to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest (Section 1(2) Public Bodies (Admission to Meetings) Act 1960)"