East Suffolk and North Essex NHS Foundation Trust

QUALITY & PATIENT SAFETY COMMITTEE

Minutes of the meeting held on 18th December 2018
Directors' Seminar Room, Trust HQ, Ipswich

PRESENT: Helen Taylor, Non-Executive Director *(Chair)*
Carole Taylor-Brown, Non-Executive Director
Laurence Collins, Non-Executive Director
Catherine Morgan, Chief Nurse
Neill Moloney, Managing Director

IN ATTENDANCE: Denver Greenhalgh, Director of Governance
Nicky Leach, Director of Logistics and Patient Services
Angela Tillett, Medical Director
Anne Rutland, Associate Director of Clinical Governance
Anna Shasha, Associate Director of Midwifery
Andy Higby, Head of Pathology Services
Shaun Jackson, Head of Estates
Sean Whatling, Associate Director of Finance - Analytics
Rebecca Pulford, Associate Director of Nursing, Integrated Pathways
Clare Harper, Senior Committee Secretary (Minutes)

OBSERVING: Helen Vanstone, Public Governor

APOLOGIES: Barbara Buckley, Chief Medical Officer
Dawn Scrafield, Director of Finance
Paul Fenton, Director of Estates
Alison Power, Director of Operations – Group 1
Kevin Purser, Chief Pharmacist
Neil Abbott, TIAA
Alan Woodhead, Mazars
Ian Marsh, Public Governor

ITEM **ACTION**

81/18 APOLOGIES/INTRODUCTIONS

1. Apologies were noted as above.

2. There were no declarations of interest noted.

82/18 MINUTES OF THE LAST MEETING

3. The minutes of the meeting held on 19th November 2018 were reviewed and accepted as a true record with the exception of the following:

- Page 10 - Paragraph 53 to be removed.

83/18 ACTION LOG

4. The Committee reviewed progress of actions received to date, noting:

- 34/18 Pathology Policies – a lot of work was underway with regard to NEESPS and co-ownership of key areas of focus for the immediate future. A comprehensive list of policies and review dates would be provided to this Committee in January 2019. **DG**

- 17/18 Breast Screening Service – A report was presented by the Site Medical Director – Colchester, which provided a position update and details of divisional oversight following a review of all screening programmes. A new Screening Round Length (SRL) plan had been implemented as part of the recovery plan to align the screening of women to within the recommended threshold of 36 months. As part of the national incident all eligible women across both areas of North Essex and East Suffolk had been invited and screened. In terms of the North East Essex Screening programme there had been significant improvement in terms of reducing delays in screening with trajectory set at January 2019 to bring the SRL to 36 months. A harm review process had been implemented for new cancers diagnosed over 38 months (cancers diagnosed in women affected by the national incident were excluded from this internal process, as a separate national process by which they will be managed was still in development). It was also noted that there was good engagement with commissioners and regular Breast Screening Programme Board meetings held.

5. The action chart would be updated and circulated with the draft minutes of this meeting.

84/18 MATTERS ARISING

IA Transportation of Specimen Handling

6. The Head of Pathology Services presented a progress update on the remedial actions against identified deficiencies and subsequent recommendations in the internal audit report relating to the transportation and receipt of specimen handling in the Pathology laboratories on the Colchester site.

7. The Committee noted that most remedial actions had been completed or were on track to complete within the stated deadlines with the exception of one action relating to the timescale for the continued roll-out of OrderComms (the electronic ordering of tests in all pathology disciplines) to all users on the Colchester site. It was agreed that the Site Medical Director – Colchester, would contact the Chair of the e-Health Board to provide a position update on OrderComms proposal for Colchester Site. **AT**

8. The Director of Governance requested that the internal audit recommendations be separated from the overall Action Plan and provide narrative around assurances for each recommendation for the next Committee meeting. **Action:** AH **AH**

ITEM **ACTION**

Pathology Services Update

9. The Committee received the update report on Pathology Services noting that since the Pathology CDG had been placed in financial and operational turnaround in November 2018, the level of senior support had been increased and a new governance structure had been agreed to meet national requirement for NEESPS (the co-owned partnership between ESNEFT and West Suffolk Hospital) with the establishment of bi-weekly Transformation Delivery Group meetings, monthly Operational Delivery Group meetings and a monthly NEESPS Strategy Board meeting.

10. The Committee noted the overview of key high risks which could affect the ability to deliver the accredited services:

    - Recruitment and retention of Band 6 BMS's, including a short term plan to provide enhanced shift allowances and a longer term phased exit from the scheme by reducing the enhancement rates each year;
    - Transformation Programme to support workstreams in achieving agreed milestones; and
    - Review of risks and mitigating actions, particularly around the regulatory intervention from MHRA at WSH.

11. The Managing Director advised that a programme of works had been outlined at the NEESPS Strategy Board meeting to develop a strategy over the next 3 months and an engagement plan for all 3 sites and large customers on how the service would be provided going forward. He added that he had been invited to attend the Scrutiny Committee meetings at WSH to provide further assurance around the partnership.

12. CT sought confirmation of delivery deadlines. The Managing Director advised that with regard to accreditation it would take some time to demonstrate that the service was being provided safely and may require extra investment in the service long term.

13. The Committee noted the current position of this service and the commitment required from both partners to make the necessary improvements. In order to provide sufficient assurance to the Board, regular updates would be provided to this Committee from the NEESPS Strategy Board. **NM/AP**

Never Events

14. The Chief Nurse presented a summary pack from the Never Events Summit which was held to review a recent cluster of 5 never events that had occurred on both sites and the subsequent progress to date, learnings identified and actions going forward.

15. The Committee noted the immediate actions agreed by the Task and Finish Group and accepted that some actions, such as Human Factor Training,

may take time to roll out.

16. LC thanked the Chief Nurse for the detailed report which he felt gave substance to each item. However, he highlighted the point made on page 11 regarding a lack of oversight in terms of evaluating action and actions being completed/signed off and suggested an audit of these to ensure processes were being followed appropriately. He added that the comments made by some staff following a review of root cause themes were of concern particularly with regard to staff feeling rushed and overseeing things as a result and urged more oversight that these actions were being completed and closed down. The Chief Nurse assured the Committee that never events were processed as a Serious Incident and closely monitored by the Serious Incident Panel for completed action plans and evidence required with a tracking process before the incident could be closed down. She added that all actions would be reviewed by the SI Panel to ensure they were fit for purpose and qualitative peer reviews were throwing up some issues that may not otherwise be seen.

17. The Director of Governance commented that actions to address issues may require further oversight and recommended for sustainability purposes going forward that these were reviewed to ensure they were being adhered to. She suggested these were included in the annual clinical audit plan and possible inclusion in NED walk arounds.

Comments/questions

18. The Chair asked whether Human Factor training had been provided in the past. The Chief Nurse advised that this training had been provided more in terms of scale on the Colchester site and pockets of training at Ipswich however it was likely that a whole days training for MDT groups would be rolled out from February 2019 with a combined site training programme going forward.

19. The Chair queried who was picking up the action required around the Surgical Site Marking policy. The Associate Director of Clinical Governance advised that this was currently part of a much larger policy and the Associate Medical Director was currently looking to separate this section to make it easier to access.

85/18 CHAIR'S KEY ISSUES – FEEDBACK FROM TRUST BOARD

20. The Quality & Patient Safety Chair's Key Issues report was received by the Trust Board at its meeting held on 29th November 2018 and subsequent Board feedback was noted by the Committee.

21. LC queried why the 2 actions relating to item 72/18 Chemotherapy Capacity had not been included in the QPS Action Chart. The Director of Governance explained that the first action around the need to focus on Demand and Capacity Modelling mitigation had been submitted to the EMC this month and the second action around the Chemotherapy Strategy

would be brought to this Committee in the near future.

22. LC sought assurance and mitigating actions on item 70/18 Safeguarding, given stabbing incidents in Ipswich at the weekend and asked whether more oversight was needed at this committee. The Chief Nurse suggested that a more detailed section in the quarterly safeguarding report could be included to cover this aspect with regular updates thereafter.

86/18 CKI'S FROM SUB COMMITTEES

23. The Committee received the Chair's Key Issues reports from its sub-committees, noting:

Infection control

- Progression of Outpatient Antibiotic Therapy (OPAT) service – due to commence shortly at the Colchester site (already in place at Ipswich).
- ESNEFT flu vaccination compliance rate was 30%, and currently within the bottom 8 acute hospitals nationally – weekly phone calls and action plans were in place. Breakdown of site base and professional uptake was being sourced to see which areas needed to be targeted.
- ICPT portfolio of policies and guidelines had been aligned and risk assessment carried out where required. All were now RAG rated to ensure key policies were completed in timely manner.

Comments/questions

24. The Director of Governance asked whether the decontamination item related to mattresses only. The Chief Nurse confirmed that the current service for decontamination of mattresses at the Ipswich site was only conducted during week days causing stock piles of mattresses over the weekends and the area used for decontamination was not fit for purpose. To mitigate this in the short term, more mattresses had been purchased and a business case was being drafted for a managed service across both sites going forward. It was noted that a Decontamination Steering Group had been established and reported to the HICC for first time this month.

25. LC queried whether more flu vaccination stations could be set up at key areas. The Chief Nurse advised that planning was not where it needed to be in order to provide this service this year however roaming clinics were being arranged and she was looking into peer vaccinators on the wards. The Chair commented that she thought the process was going to be more clinically led this year however she had not seen any evidence of this. The Managing Director advised that this had been raised at the Medical Staffing Committee (MSC) and the key issue appeared to be the lack of access to the vaccinations. The Chief Nurse advised that the original vaccination plan would continue whilst a 'catch up' strategy rolled out. CT commented that the POD Committee would be providing oversight for next year's vaccination programme to get ahead of the game.

Patient Safety

- Continued oversight required regarding numbers of staff trained in restrictive practice in Paediatrics in ED.
- No Consultant Lead for Nutrition at Colchester due to vacancies for consultant Endoscopists. All consultants currently supporting on a rotational basis.
- A recent inquest outcome highlighted the need to remain highly focussed on Sepsis.

Clinical Audit & Effectiveness Group

- Revised EDS template for Colchester site to bring in line with national guidelines for EOL care, which would include instructions for GPs post discharge.
- Issues relating to mobile connectivity in the community – IT had identified concerns within their strategy and were supporting the community teams.

Medicines Optimisation Committee

- Omitted doses remains a concern
- Challenges continue in managing medication shortages, in particular Furosemide injection;
- An outline business case for an ESNEFT Electronic Prescribing and Medicines Administration (EPMA) project was due to be completed in December.

Comments/Question

26. The Site Medical Director highlighted the need for full commitment by the Trust with regard to the proposal for an EPMA system. The Chair sought clarity around the anticipated timescale of this project and it was confirmed that once the outline business case had been approved followed by a consultation process with the clinical teams to decide what systems would be relevant for ESNEFT with a view to tender in early 2019 and first pilot of the system from August/early 2020.

87/18 KEY QUALITY OR SAFETY ISSUES

27. The Chief Nurse advised the Committee of the following key quality and safety issues:
    - Winter capacity and flow were challenging and escalation beds were already being utilised on all sites.
    - There had been an increase in the need for Paediatric inpatient beds at Ipswich and due to capacity challenges this had required the transfer out of some children.

Comments/questions

28. The Managing Director commented that focus for winter planning was mainly relating to adults however the current demand in Paediatrics would suggest that further work was required to address this issue for next year's winter planning. It was noted that one of the challenges was around workforce and how we recruit to these difficult to recruit to posts. He added

that there had been some staffing challenges following the transfer of the re-ablement service from Allied Health Care to ECL and the domiciliary care transferring to ACE, however, there had been good engagement from service partners and a list of senior decision makers had been made available over the Christmas period for any escalations.

88/18 INTEGRATED PATIENT SAFETY AND EXPERIENCE REPORT – QUALITY DASHBOARD

29. The Committee received the Patient Safety and Experience - Quality Dashboard (November 2018 data), noting:

- 1 never event – wrong route administration of medication – investigations was on-going
- Sepsis/deteriorating patient – work in progress around aligning Ipswich data reporting. Staff were in place to support collection of this data going forward.
- 38 (50) complaints received at Colchester compared to 59 (57) at Ipswich – focussed piece of work was underway to support one division to improve the response rate position and further work on long overdue complaints.
- 80 inpatient falls reported at Colchester, 80 falls at Ipswich and 36 at Community hospitals. A New falls lead was due to join the Trust in February 2019 and will build on the work being rolled out by the Harm Free Care Team across both sites in January 2018.

Comments/questions

30. The Chair commented that the level of detail was very helpful, particularly relating to cross site learning.

31. The Director of Governance commented that whilst the aggregated information for Ipswich was helpful she asked whether it was possible to separate community from acute beds. **AR**

32. LC queried whether ward heatmaps had been dropped from the Quality Dashboard as felt that it was helpful to see how wards were performing. The Chief Nurse advised that the level of detail was no longer provided at this committee as some of the measures were not appropriate for all wards however nurse sensitive data was produced in weekly heatmaps which was unvalidated data. LC commented that at the beginning of ESNEFT, the Committee had agreed to review these metrics and he was interested to know the outcome. The Chief Nurse advised that the review of ward metrics, included ward accreditation which looked at a realm of metrics, good practice, ward rounds, etc. which would provide a more holistic and qualitative view of ward performance. However, the data and methodology were different on each site therefore further work would be required to align this data for next financial year. The Managing Director commented that the Committee did commit to review metrics within the Accountability Framework once ESNEFT had been established and he suggested that until

this had been completed any questions should be raised at these meetings.

Community Services

33. The Associate Director of Nursing for Integrated Pathways presented the Quality data for East Community Services, drawing attention to the Barthel scores which gauge the dependency of each patient with an aim to improve each patient score in order to discharge them back to where they would like to be i.e. home.

34. The Committee accepted that there were a number of falls at Bluebird Lodge due to the rehabilitation programme in place and were assured that each patient was being risk assessed before commencing the programme.

Comments/questions

35. The Director of Governance sought clarity around the analysis for the number of inpatients transferred as an emergency to acute care (within 72 hours). The Associate Director of Nursing advised that following a deep dive into transfers to the acute sector, the number of patients going to community settings had not increased and the readmission rate remained between 3-4% however she was happy to provide a slide pack going forward.

RP

36. The Director of Governance commented that data for GP Federation had not been included for oversight at this Committee. The Associate Director of Nursing would provide this going forward.

Mortality Report

37. The Site Medical Director presented the Learning from Deaths, Mortality and HSMR report, advising that:

- Cross-community mortality reviews had commenced following a cluster of unexpected deaths in a Tendring residential care home;
- 7 deaths in November where patients had learning disabilities were being investigated with support from the Learning Disabilities Nurse Specialist;
- Ipswich HSMR was 93.0 whilst 23% of coded activity for Colchester missed the first data deadline for Dr Foster and was therefore incomplete – external coding support was being provided at Ipswich so that staff could be freed-up to support Colchester coders;
- Crude mortality rates for Colchester were still significantly higher than national and Ipswich was close to the national rate;
- Ipswich SHMI was 107.35 (105.01) and within the expected range. Colchester SHMI was 113.76 (114.27) and within the expected range;
- 10 active CUSUM alerts on the dashboard 3 of which have triggered

externally;

Comments/questions

38. The Chair asked whether the Learnings from Deaths would go to LeDer Process. The Site Medical Director advised that this may be discontinued from March therefore there was a need to ensure that reviews take place locally in the meantime.

Comments

39. The Managing Director commented that HSMR at Colchester showed a significant increase in-month which he assumed was due to the coding issues earlier in the year and sought assurance on what was being done to resolve the coding issues. The Site Medical Director advised that in-month data was subject to variation and a clinical coding report had been submitted for discussion later on the agenda.

Falls Prevention Quarter 2 Report

40. The Committee received and noted the Falls Prevention Quarter 2 Report.

Tissue Viability Quarter 2 Report

41. The Committee received and noted the Tissue Viability Quarter 2 report.

89/18 INFECTION PREVENTION AND CONTROL MONTHLY REPORT

42. The Chief Nurse presented the Infection Prevention and Control report (November 2018 data) to the Committee, noting:

- Increase in C.difficile cases;
- Pseudomonas and Klebsiella bacteraemia cases remain low with no resistance patterns noted;
- Inaugural meeting the joint Trust Decontamination Committee took place in October – review of long term planning required for the management of endoscope reprocessing on the Clacton OPD site;
- No cases of ward or bay closures due to Norovirus

43. The Committee received and noted the report.

90/18 INTERNAL AUDIT – COMPLAINTS

44. The Committee received a report following an internal audit review of Complaints which was given a 'satisfactory' assurance by the internal audit team.

45. The Committee noted that whilst procedures were in place for dealing with complaints received there were areas identified which required further improvement in the control environment and an action plan had been produced based on the 5 priority 2 recommendations made within the report.

Comments/questions

46. The Director of Governance commented that the narrative within the report did not give the impression that satisfactory assurance had been given. The Associate Director of Clinical Governance advised that the audit was originally intended for the Colchester site only however this was changed to include both sites which may have skewed the narrative. She added that separate processes were being followed on each site and therefore the audit looked at compliance of processes in place against the policy which gave the satisfactory assurance.

47. The Chief Nurse commented that 1 outlier represented a response rate within 28 days which is a known current concerns having been reported at both QPS and EMC with a recovery plan.

48. LC queried when a single system across both sites would be rolled out at Colchester and which assurance committee would have oversight. It was noted to be rolled out from March 2019 and the Audit Committee would receive regular updates.

91/18 MEDICAL DEVICES MANAGEMENT REPORT

49. The Head of Estates presented an update on compliance following the medical equipment audit carried out across ESNEFT.

50. It was noted that the Trust was compliant on the Colchester site however further work was required at Ipswich as overall compliance was not within the Trust set targets mainly due to a decentralised approach to the management of medical devices on the Ipswich site which ranged from contracts being managed locally by clinical departments to a large proportion of medical devices being maintained by the Estates Department. The devices were not held on a central database and as a result many devices may not have been maintained in line with manufacturer's instructions.

51. The Head of Estates advised that by mirroring the centralised approach to both the maintenance contracts and the devices replacement programme at the Colchester site, there would be a significant increase in compliance rate, a substantial saving to the Trust through the reduction in numbers of medical devices required to provide current medical services, and further savings would be possible through the consolidation of contracts due to single orders with suppliers and standardisation of equipment and purchasing replacement devices in bulk.

52. The Committee noted the ENESFT Electro-Biomedical Engineering (EBME) plan to nominate a company to carry out the audit of devices on Ipswich and Community sites and create a centralised management facility. The audit would represent a circa £100k cost pressure to the EBME function. In the meantime a detailed action plan was in place to address the areas of non-compliance and any associated risks at Ipswich.

Comments/questions

53. The Chair sought clarity in terms of the cost pressure. The Head of Estates confirmed that the immediate cost pressure would be around £50k and this was currently with Finance for consideration.

54. The Managing Director asked which assurance committee this had been to. The Head of Estates advised that it had been submitted to the EME Group and Health & Safety Committee but accepted that this needed to go through an assurance committee.

55. The Director of Governance commented that this Committee should seek assurance around meeting the totality of the MHRA guidance on managing medical devices rather than confining oversight to the servicing and maintenance of the medical devices. The Head of Estates advised that the audit of equipment would enable the EBME to have better oversight of the equipment maintenance and a review of all contracts would be matched to Colchester and re-contracted where it may be more cost effective. The Director of Governance sought assurance on competencies and compliance. The Head of Estates believed this may be covered within Nursing competencies but not competencies in its entirety.

56. The Site Medical Director expressed her concerns around the non-compliance of high risk equipment such as ventilators and sought assurance on when they would be audited. It was noted that most high risk equipment had already been added to the central database.

57. The Committee noted that the business case for works to be carried out to form a centralised database was the sensible way forward and mitigating actions would be progressed to prioritise equipment in order to remain compliant with regulations. The Chair suggested that the Site Medical Director at Ipswich should be asked as the SRO for medical devices to provide a full report under matters arising next month including our approach to meeting the MHRA. **Action: CJ** **CJ**

92/18 CQC INSPECTION REPORTS ACTIONS UPDATE

58. The Committee received a request to defer this report to January to ensure accurate validated training data was provided.

93/18 CLINICAL CODING QUARTERLY UPDATE

59. The Committee received and noted a report from the Chief Medical Officer which summarised the current situation relating to concerns around the sustainability of the clinical coding function (BAF Risk Q10).

60. It was noted that in January 2018 there was a backlog of uncoded episodes on both sites of circa. 8,500 at Ipswich which was reduced down to 2814 following periodic external support and increased overtime from the team. During the same period Colchester backlog had increased from 2079 to 3169.

61. The Site Medical Director explained that longer stay patients were often more complicated to code as the system it only accepts the first 14 codes therefore if a patient has a greater number of codes they will be not taken into account when coding.

62. Both sites continue to struggle to recruit trained staff and have 6 clinical coding trainees who commenced in November and will take 2 years to qualify. A number of actions have therefore been put in place to significantly reduce the backlog resulting in a reduction in backlog of 45% at Ipswich and 34% at Colchester. The current vacancy rate is 36.6% and the department was heavily reliant on external coders contracted to the team but this was not sustainable long term.

63. It was anticipated that that the backlog would reduce to 6 days (4k) by February 2019.

Comments/questions

64. LC asked for an update on the meeting with Guy's and St. Thomas' in November. It was noted that clinical engagement was positive, however further support was required with clinical coding on discharge and where there was a number of co-morbidities, these needed to be uploaded in the correct order.

65. The Committee received the report and noted the continuing challenges.

94/18 QPS RISKS

66. The Director of Governance presented the risk oversight report on all risks with a score of 15 or above which are associated with the portfolio of the Quality and Patient Safety Committee.

67. The Committee noted that of the 5 risks scoring 15 or above, 2 had been de-escalated:

- Risk 426 relating to Chemotherapy Capacity at Colchester Day Unit was initially raised as a 16 rated risk however following recent successful changes to mitigate the capacity risk this risk was reduced to a 9.

- Risk 362 relating to specimen Management had been a regular agenda item at the QPS Committee and would be de-escalated from a 15 to an 8 following approval that sufficient assurance had been provided to this Committee.

68. The Director of Governance advised that Sepsis would continue to be included within the quality report each month. The overdue policies were noted to be overseen by the Audit & Risk Assurance Committee. However a report on the clinical guidelines would be provided for information.

Comments/questions

69. LC asked whether the management of medical devices was on the risk register. It was noted that this was on the risk register with a risk score of 12, therefore not highlighted at this committee. The Committee members discussed whether QPS should see risks with a score of 12 and above rather than 15.

95/18 6 MONTHLY REVIEW OF COMMITTEE EFFECTIVENESS

70. The Committee received a report from the Company Secretary which outlined the proposed process for a 6 monthly review of evaluating this Committee's effectiveness. The proposal was for a two-stage process using two separate checklists in order to ascertain whether the committee was getting the right balance of reporting and how effective this was.

71. It was noted that historically only committee members were required to complete the online survey tool and it was agreed that all committee members and attendees would be asked to participate. **AA**

72. The Company Secretary would liaise with the Chair of the Committee with regard to the survey questions and circulate the link to the online survey shortly. Given the timescale, there may not need to be a repeat of this process at the end of the financial year. **AA/HT**

96/18 QUALITY ACCOUNT FORMAT AND TIMELINE

73. The Associate Director of Clinical Governance provided a verbal update on the proposed format and timeline of the Quality Account Report, advising that submission dates had been agreed with key information providers and a first draft would be provided by the end of February which would require support from ESNEFT Governors with regard to approving priorities for next year.

Comments/questions

74. The Director of Governance commented that this Committee's role was to provide assurance to the Board of Directors that the Quality Account had been developed in line with and adhered to the Quality Account Regulations. To discharge this responsibility the Committee should receive a report detailing the requirements and mandated text for reference at the point of reviewing the Quality Account. The Associate Director of Clinical Governance advised that she could provide a schematic of what was included last year.

75. The Chief Nurse asked what the process was for deciding the priorities for next year. It was noted that a long list would be reviewed before a shortlist was confirmed. The Chair commented that it would be helpful to have a discussion at this Committee before it goes to the Governors in February.

76. HV (Public Governor) commented that the next Public Governors meeting

was due to be held in March.

77. The Managing Director highlighted the importance of engaging with clinical priorities and business plans to ensure the quality priorities were not operational based.

97/18 PUBLIC GOVENOR OBSERVATIONS

78. HV (Public Governor) sought clarity around psychiatric liaison representation. The Managing Director advised that there was a psychiatric liaison centre on various sites however he recognised that further developments were required. He added that there had been some enhancements on the Ipswich site following investment for a psychiatric liaison post and that the ambition was to have discussions with the STP to help with support in mental health provision.

79. HV (Public Governor) queried whether governors would be able to support on PLACE Assessment visits. It was noted that Fiona Sparrow was heading this up with a roll out of visits in April 2019.

Date of next Meeting

Tuesday, 22 January 2019, 09:30hrs-11:30hrs, Directors' Seminar Room (DSR), Trust HQ, Ipswich