The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

Minutes of the meeting held Tuesday 26th November 2019 at 10am in the Conference Room, Queen Elizabeth Hospital, King's Lynn

Present:

S Barnett (SB)	QEH Trust Chairman
A Brown (AB)	NED
I Mack (IM)	NED
S Roberts (SR)	NED
G Ward (GW)	NED
D Dickinson (DD)	NED
J Schneider (JS)	NED
C Shaw (CS)	CEO
L McManus (EM)	Chief Nurse
L Sanford (LS)	Director of Finance & Resources
D Smith (DS)	COO
F Swords (FS)	MD
L Skaife-Knight (LSK)	Deputy CEO
C O'Brien (COB)	Director of Patient Safety

In attendance:

I Semmon (IS)	Patient Story
L Notley (LN) - item 13	Associate Director of Quality Improvement
C West Burnham (CWB)	Assoc. Director Strategy
C Castleton (CC)	Assoc. Director HR
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer – minutes

ACTION

187/19 1. CHAIR'S WELCOME

SB welcomed those present to the meeting.

188/19 2. PATIENT STORY

DS introduced IS who had surgery at QEH in October 2018.

IS explained that 3 years ago he underwent a procedure in Day Surgery which was successful; however, there was an issue in relation to prescribing of antibiotics. IS felt unwell at home and was taken by ambulance to NNUH where he was diagnosed with sepsis. It took him c9 months to recover.

IS also voiced concern in relation to the Trust's telephone reminder service. He received a telephone call asking if he would be attending his Day Surgery appointment – IS had concerns that the call had been made by staff from an external organisation (FourEyes). IS advised that it took 7 months for his complaint to be resolved.

Following his procedure, IS was told he would be reviewed in 3 months; however, he was not seen for 7 months. During the intervening period IS experienced a series of infections and felt frustrated.

IS explained that his son, who had a needle phobia, had to have a wisdom tooth extracted in 2019 and phobia was not taken seriously by the dental surgeon.

SB thanks IS for sharing his experience and apologised on behalf of the Trust for the treatment IS and his son had received. DS advised that Urology is a high demand specialty with a significant backlog; delays in outpatient follow-up appointments were being monitored by speciality and improvement actions were in place.

IS will speak to his son to arrange a meeting with a matron and Exec lead in relation to his concerns, and CS and FS have spoken to the individual consultant in oral surgery who will undertake specific training to improve patient relations. All medical staff complaints are fed into the appraisal process; previously this had not included dental but will do so going forward.

CS thanked IS and gave her apologies. She acknowledged that there was room for improvement in IS's care but reminded the Board that many positive improvements are being made, such as performance in hip replacements, stroke care and breast care.

The Board noted the Patient Story

189/19 3. REVISITING THE PATIENT STORY

The Board considered the report and discussion included:

The previous patient story had related to a patient who had told of her positive experience having her baby here. Whilst most of her account was positive there were areas where care could be improved.

EM had shared the positive elements with midwifery staff and the patient went to thank a specific individual straight after the Board meeting.

All staff are now aware that hot drinks should be offered to all patients, and their partners.

The induction of labour pathway was too long; significant changes in the pathway will be reported to the Quality & Performance Committee. IM welcomed the comments on the induction pathway and felt it was important to hear back at Public Board to ensure this is embedded.

The Board noted the follow-up on the Patient Story.

190/19 4. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 29th OCTOBER 2019 / MATTERS ARISING

The Board considered the minutes and the following changes were requested:

Page 4, minutes 171/19, 3rd bullet to read: 'EM has agreed a change in resource in November'.

The minutes of the meeting held on 29th October were considered to be an accurate record of the meeting subject to the amendment above.

191/19 5. ACTIONS MONITORING

The Board reviewed and updated the Actions Monitoring Record. The following actions were considered complete and were removed from the action log: **36, 49 and 51 from 2018 (added to Forward Plan), 54, 57, 95, 96, 97, 99 and 100.**

IM referred to minute 171/19 and asked FS to provide a plan for addressing treatment of patients who attend ED with an undiagnosed aneurysm; FS will provide a plan at Quality & Performance Committee in January. **MD**

See Action Log for further updates.

192/19 6. DECLARATIONS OF INTEREST

GW reminded the Board that he was also a non-executive director at Sherwood Forest Hospital.

193/19 7. URGENT ACTIONS (Under Standing Order Para. 5.2)

Submission of the approval of the 5 Year Strategic Plan was noted by the Board.

194/19 8. CHAIRMAN'S REPORT

The Board considered the report and discussion included:

- SB advised that CS would highlight the awards evening in her report, but he wished to thank those colleagues who had worked so hard to ensure the evening was successful. SB also thanked the award winners, adding that it was a pleasure to celebrate such fantastic achievements.

- SB reminded the Board about the current purdah status, so the Trust must take care in its external communications that it does not appear to support any political party.

- The STP 5 Year Plan has been welcomed by regional leaders; trusts need to ensure that finances underpinning the plan are deliverable.

- The Trust has undertaken a Board-to-Board-to-Board meeting with NNUH and JPH, which had proved positive. SB was looking forward to seeing a programme of similar events going forward to underpin integrated working.

- The QEH is one of 25 Trusts who will soon be implementing Electronic Prescribing and Medicines Administration (EPMA) plans. This will provide a safer, more efficient service for patients, as well as being more cost efficient.

The Board noted the Chairman's Report

195/19 9. CEO's UPDATE

The Board considered the report and discussion included:

- The Staff Awards evening was held in November for the first time in recent years; staff engagement was excellent, with over 400 nominations, and more than 200 staff in attendance. The evening was a great success and has resulted in staff feeling more valued and proud

to work at QEH again.

- There will be a programme of events to take place over the next year aimed at thanking staff an encouraging them to feel part of #TeamQEH during its 40-year anniversary year.

- CS welcomed COB to the Executive team as interim Director of Patient Safety.

- The Trust also has a new Improvement Director, Dr April Brown, who was appointed following Alan Thorne's retirement. April is an experienced senior nurse who will focus on professional standards.

- CS thanked the League of Friends, which continues to support the Trust, improving both staff and patient experience.

- CS and SB attended the MoD Employer Recognition Award evening in Cambridge; the Trust was awarded a silver award and CS reported her aspiration to achieve the gold award next year through further engagement with RAF Marham.

- QEH welcomed inspectors from NHS Improvement/England and West Norfolk CCG for an Infection Prevention and Control inspection, which found improving standards of cleanliness and infection control practice across the organisation. Feedback was highly positive, with the Trust receiving an 'amber' rating; the Trust would have received a 'green' rating, had improved practices been fully embedded.

- CS acknowledged that the Trust still faces significant challenges but that improved energy and focus are noticeable across the organisation.

- IM felt that the IPAC inspection was an exemplar of how the Trust should work going forward, i.e. constructive challenge by NEDs followed by direct action by Execs and delivery by well-motivated front-line staff. He thanked all involved.

Dep. CEO

- SR echoed CS' comments relating to increased positivity following the awards evening and queried whether this included those staff who did not attend – CS felt it had, with those present communicating to their teams via social media. She felt this would encourage healthy competition for nominations next year. **LSK will bring a staff engagement plan to the People Committee in January, then to Board in February.**

The Board noted the CEO's Report

INTEGRATED PERFORMANCE REPORT

196/19 10a. SAFE

The Board considered the report and discussion included:

EM highlighted:

- IPAC / cleaning – she was disappointed that the Trust had reported its first case of MRSA bacteraemia in 543 days. This occurred in ITU and a full RCA was undertaken, which identified areas for improvement, i.e.

documentation and management of line insertion. The clinical team is fully engaged with the investigation.

- C.Difficile - 8 reported cases, was a cause for concern but a review of the timeline did not identify a link between cases. Wards are adhering to policies in relation to cleaning and patient movement. DS and EM have been clear to the Ops Centre when patients can be moved. Fogging is taking place on Stanhoe to ensure it is deep cleaned.

- Cleaning – DS and EM highlighted concerns regarding the fundamental standards across Trust to Board and Quality & Performance. Wards have been 'spring cleaned' and cleaning scores have significantly improved. The aim is to recruit 8 WTE cleaning staff to ensure that standards are maintained.

- COB advised that the way SIs are recorded has changed, so reported numbers may appear different to those in the IPR. She suggested adhering to the date of declaration rather than occurrence. SB advised that explanation in the report is important.

- A Never Event was declared in November and related to the WHO checklist. New staff safety alerts have started.

GW was pleased to see the improvement in cleaning performance, despite the high sickness levels and recruitment issues.

AB referred to the MRSA case, explaining that he had visited ITU last week, and received a full explanation of the RCA. Advice from microbiologists had been received and increased swab sites had been rolled out. **Dir. Pt Safety**

IM referred to the deteriorating patient, noting that the action plan was in progress but felt this failed to provide assurance; he sought clarity on what actions were being taken – COB will update at the next meeting.

SR referred to the mental health breach, a similar issues also having been reported in a previous Patient Story, and queried how plans to address breaches with community partners was progressing – COB advised that a wider review would take place for January. There are challenges in getting specialised commissioners to engage and this is being progressed with the CCG and NHSE/I. DS added that the Trust has a better relationship with the mental health trust, which has increased inpatient capacity by 16 beds locally, and introduced national guidance to reduce length of stay. QEH is working with them and commissioners to identify an external location where patients can wait for a bed rather than wait in the ED. The STP executive has been proactive regarding additional beds but utilisation remains a challenge as every effort is made to ensure that patients stay within the local area where possible.

197/19 10b. EFFECTIVE

The Board considered the report and discussion included:

- Both HSMR and SHMI mortality indicators are 'as expected'.
- There was a single data point increase for weekend mortality rates – if this continues FS will review.
- The 7-day service report is due at the next meeting.

- Raghu Govindan, deputy MD, started in post last week.
- Maternity – the recent reduction in C-section rates has been sustained and is below 25% for the 2nd consecutive month for both planned and unplanned deliveries. The team has implemented a suite of actions and an audit has been undertaken to identify which is most likely to result in improvement sustainability.
- Clinical research remains on track to exceed the recruitment target for this year and has achieved funding targets to date.
- Areas for improvement include avoidable term admissions to NICU; this reached 20% and following a deep-dive 4 admissions were found to be avoidable. One was due to the mother's admission – her twins could have gone to the transitional unit. The other 2 were both babies who were readmitted with post-labour jaundice; both had been identified 48 hours before admission so reflected a pathway issue.

- SB thanked the gynaecology team for the sustained reduction in C-section rates.

- **JS referred to term admissions to NICU and queried whether FS was satisfied with staff training. FS advised that the whole pathway had been revised and this now requires embedding. Cultural work is being undertaken between midwifery and the paeds team and enormous improvements in multi-disciplinary working have been noted. FS and EM are working with CC to improve multi-disciplinary working across the Trust. SB asked to be kept aware of term admissions to NICU and the impact of actions taken. AB noted that the graph on page 19 did not align with the data. MD to correct.** **MD**

- DD referred to clinical audit and queried why data on the national inflammatory bowel audit and End-of-life audit had not been submitted. FS advised that the failure to submit data for the inflammatory bowel audit related to an issue with software, followed by an issue with competing clinical priorities; this has been addressed by a plan to submit data regularly from January. The End-of-life audit data is submitted every year; the dashboard appears as expected but the Trust omitted to circulate a questionnaire to patients / families. Once the error had been recognised, QEH asked if could circulate the questionnaire late and submit but this was refused. The Trust is on track for submission next year and can assimilate the learning.

- JS queried whether there was any representation from community partners on the Mortality Review panel - FS advised that community partners were invited on an ad-hoc basis, although they are involved in action plans.

198/19 10c. CARING

The Board considered the report and discussion included:

- Complaints – there has been an improvement in performance, but further work is needed. Additional resource has been put in place and EM is meeting the team each day.
- EM is using PTL methodology for waiting list management. Data will be included in the report from December.
- If the run-rate continues at current rates the Trust will be 95% compliant by March 2020.

- EM has ensured learning is being identified from complaints and is working with divisions.

CS felt this was a proactive report but the focus must be to reduce the causes of complaints; she wants to introduce a shared governance model for nursing and medical staff as a significant number of complaints relate to behaviours / attitudes (to go to Quality & Performance Committee and People Committee in February). CS also suggested implementing a 'pathway to excellence' project to motivate staff. **Chief Nurse**

GW would like to see a trajectory in the report, along with themes and actions taken. He felt the impact on complainants can be worsened when responses are delayed and queried whether they were kept informed – EM advised that they had not been in the past, but the team are doing so now. **Chief Nurse / Chair of Quality Cmte**
AB referred to the FFT results for maternity, which had seen several decreases and was below target; he felt this should be investigated and reported to Board via Quality & Performance Committee Chair's Assurance report.

IM noted that there had been no improvement in dementia case finding and queried when the Board would see an improvement. EM advised that the new stickers went 'live' on 15th October; she anticipated seeing an improvement in data in November. Targeted work has taken place, supporting doctors to carry out the test and complete the documentation. The impact of this should be seen in December / January. EM to update IM outside the meeting. **Chief Nurse**

199/19 10d. RESPONSIVE

The Board considered the report and discussion included:

- Emergency care – there has been a deterioration in 4-hour performance nationally. QEH is a type 1 organisation and is currently rated in the middle of the table nationally; however, the aspiration is to be in the top 10, achieving performance in the high 70s / low 80s.
- Estates work is ongoing, and this will have a significant impact – this includes additional capacity in the Discharge Lounge and provision of same-day care. Work will be complete by the end of March.
- There is a new divisional manager in Medicine, focussed on patient care, patient experience and access in the ED. The priority is to eliminate 4-hour breaches in Minors and paeds; a reduction in the run-rate in these areas could result in a 5% performance improvement.
- 2020 Delivery is working with ward leaders on pre-noon discharges. There has been good engagement from nursing staff, with some wards achieving 20-30% of discharges taking place pre-noon.
- Work is required with system partners on timely discharges.
- There has been a slight improvement in ATTs for <15 minutes; the Trust is also achieving 70% <30 mins.
- There have been no 52-week breaches.
- Patients waiting over 40 weeks are monitored closely.
- 6-week diagnostics achieved 98.62%. There had been a national shortage of contrast medium for scans, but this is now resolved.
- Cancer - 31-day for subsequent drug therapy performance deteriorated from 100% in August to 97.41% in September, against the standard of 98%. This was due to small numbers of patients and one breach, which had recorded the incorrect decision to treat – this will be corrected.
- Cancer - 62 days. A significant number of patients had been treated.

Performance is slightly ahead of trajectory and the backlog is reducing.

SB suggested that it would be useful to see which action has been most beneficial in improving 4-hour performance. DS advised that the Trust can track individual metrics but felt improvement was likely to be due to a combination of actions. Performance will be monitored closely.

DD noted the increase in attendances and queried whether DS expected to see a further dip in performance as the Trust approaches the peak winter period - DS did not.

AB noted that there had been 13,500 patients on the waiting list in March, rising to 14,000 currently, and he queried whether there were any financial implications for the Trust - DS advised that there were no financial penalties.

FS attended a lung cancer GIRFT meeting this morning and QEH is ranked top in the country for 31-day cancer performance.

200/19 10e. WELL-LED – PEOPLE

The Board considered the report and discussion included:

- Sickness - training for managers has been provided, along with greater analysis of data. There was robust discussion at People Committee and divisions will attend committee to present their plans for addressing sickness.
- Mandatory training – plans in place to make it easier to complete via e-learning.
- The vacancy rate for nurses is 5%.

AB calculated that current staff sickness levels are costing the hospital £6m per year, plus agency premium costs. The Trust must understand and address the reasons for sickness and reduce levels. CC advised that as well as training managers, the Trust is working with Unison on mental health support, creating mental health ambassadors, and fast-tracking staff for support. In addition, CC is reviewing the top 50 cases of long- and short-term sickness absence. SB was clear that this must continue to be monitored at People Committee. **HRD**

GW felt it would be useful to see a graph on sickness for monitoring purposes – he was keen to see the split between long- and short-term absences. CC advised that the figures are nearly the same this month.

CS was clear that although the Trust must achieve its targets, the central priority is safe, compassionate care for patients.

201/19 10e. WELL-LED – FINANCE

The Board considered the report and discussion included:

- The Trust is £0.2m off-Plan as at month 7. Drivers include pay costs above budgeted levels, double running of new nurses, junior doctors' pay awards, and additional nurse recruitment costs.
- The Trust has delivered its CIP Plan year-to-date.
- The Trust is considering freezing recruitment for Admin & Clerical staff

and freezing discretionary spend.
- The Trust is continuing to attract external funding.

SB noted that despite the slight adverse position, financially the Trust's financial performance is much better than in previous years.

The Board noted the IPR Exception Reports

202/19 11. KEY PLANS – CANCER CARE IMPROVEMENT PLAN

The Board considered the report and discussion included:

- Improved escalation appears to be embedded; and relationships with tertiary providers have also improved, resulting in a reducing backlog.
- The colorectal team is working well and is focussed on improvement.
- Gynaecology has good plans in place, but these have yet to come to fruition.
- DS is concerned about Urology – the team's capacity issues are ongoing, despite additional support in place.
- Radiology is making improvements.
- Following DS' request for external support, the IST team starts at QEH in December.

COO

IM referred to Appendix C, noting that several deadlines had not been met, and there was no clarity of when actions will take place. DS will report to Quality & Performance monthly from January. SB added that deadlines must be achievable and meaningful.

SR queried whether there would be implications of the urology service transfer – DS advised that there would be no changes and Execs will continue to work with the team.

COO / Dir. Pt Safety

COB queried whether DS was confident that GPs are ensuring patients are aware of the importance of attending promptly for appointments on the cancer pathway – DS/COB to discuss outside the meeting.

The Board noted the Urgent Care Improvement Plan

203/19 12. WINTER PLAN 2019/20

DS advised that the Trust's Winter Plan had been received positively.

The Board noted the Winter Plan update

QUALITY

204/19 13. UPDATE ON PROGERSS - INTEGRATED QUALITY IMPROVEMENT PLAN

The Board considered the report and discussion included:

- The re-set of the plan had been discussed at a Board Development session; CS thanked LN for her input.
- The new assurance reporting template will be live from January.
- 47 duplicate 'musts and shoulds' have been removed.
- 50 'musts and shoulds' have been completed.

- 2 conditions have been internally closed in Radiology.
- There are ongoing concerns regarding capability and capacity within Medicine – 2 of the Quality Improvement team have been drafted into the division to help and this is working well.
- Work on the deteriorating patient is slightly behind plan; there is a meeting in November to address issues and the deputy MD will lead the work. Two workshops are also planned.

SR felt the report provided a level of assurance regarding the volume of work being undertaken to address actions / conditions; however, he felt graphical representation would be beneficial. CS advised that a 'plan on a page' is being developed for each area, and a report will go to Board from February. **Dir. Financial Recovery**

AB queried the robustness of the Evidence Assurance Group (EAG), as the recent Never Event related to the WHO checklist, despite being signed off by the group. LN advised that discussions at EAG related to the specific 'must' in main theatres but there is another piece of work measuring use of the WHO checklist in other areas as part of ongoing improvement work. EM is Chair of EAG and explained that the challenge is for evidence to be implemented sustainably. **EM and COB have asked the team to carry out a 'sense check' on the local and national process for the WHO checklist and they will take it to Quality & Performance in January.** **Chief Nurse / Dir. Pt Safety**

GW felt this was a good report; however, he was unclear how many 'musts and shoulds' are expected to improve this month so requested a graph depicting how many to expect and the current position. LN advised that the new reporting template from January will show rag-rated data.

The Board noted the Integrated Quality Improvement Plan update

205/19 13a. LEADERSHIP & MANAGEMENT STRATEGIC PRIORITIES: COMPLETION OF MUST AND SHOULD DO ACTIONS

The Board considered the report and discussion included:

- In the strategic plan the key objective relates to the development of leadership. The CQC was critical of the Board and its leadership in its last report. There were 8 'musts' relating to leadership – 6 are awaiting the Board's approval for closure, and the final 2 will be monitored.
- The 2 outstanding 'musts' relate to ensuring there is a process for risk management and quality improvement; and increasing the accountability of clinicians – this is happening but requires evidencing.

IM was grateful for the report and data and queried whether divisional leadership was embedded sufficiently to be signed off – CS advised that the CQC report was about structure of the leadership team and she believed this had been addressed. SB asked to see evidence at the next meeting. **CEO**

The Board approved internal closure of 5 of the 6 'musts' but sought more evidence on the 6th relating to divisional leadership.

CS advised that LN had been through the regional assessment as part of the talent management programme and was considered to be ready for a director's post – the Board offered its congratulations.

The Board approved the closure of 5 of the 'Must Do' Actions within the

Strategic Priority of Leadership and Management

206/19 14. NATIONAL INPATIENT SURVEY – ACTION PLAN

The Board considered the report and discussion included:

- EM advised that hospital food proved popular with patients.
- The data period was 18 months ago; it takes many months for trusts to receive the report.
- EM is focussing on noise at night, with the move to soft close bins and understanding what is causing the noise on the wards.
- At the time of the data capture, there were not enough nurses on duty but that is no longer the case, so staff need to be encouraged to change the language they use when talking to patients.
- 2 divisional Heads of Nursing have developed this action plan with Emma Harrison, and they are taking ownership of it.

CS was surprised that surveys did not routinely come to Board / subcommittees.

DD queried whether data for 2019 has been collected and if so, did it pre-date these improvements - EM advised that it did pre-date the improvements.

LSK felt that the noise at night issue linked with FFT results. Despite actions being completed on the survey, the FFT results still report this as an issue. EM will drill down into the data to see whether actions are embedded. Results to go to Quality & Performance in January. **Chief Nurse**

The Board noted the National Inpatient Survey Action Plan

207/19 15. QUALITY – ACTION PLAN FOR NATIONAL AUDIT OF CARE AT THE END OF LIFE

- The action plan has been developed with partners.
- **The draft strategy will be going to Quality & Performance Committee in January.** **Dir. Pt Safety**
- JS is the lead NED for end-of-life care.
- CS was clear that there should be a single action plan, aligned with the IQIP.

The Board noted the action plan in relation to Care at the End-of-Life

RISK

208/19 16. CORPORATE RISK REGISTER (>15)

The Board considered the risk register and discussion included:

- 1 new risk had ben escalated relating to beds within CDS which are not considered fit for purpose due to rust.

- IM noted that the risk relating to temporary cardiac pacing had been downgraded from 'catastrophic' to 'major' due to mitigation of availability of a 24-hour crash team. FS confirmed that the cardiology team had been involved in the decision and felt that the cover and

access to pacing at Papworth was acceptable. There had not been any incidents.

- SR referred to the presentation of the report and asked to see the top risks on the summary page. CS confirmed that the report will be presented differently in future as COB is now in post.

- SB referred to risk 2594, noting that if a replacement programme is available then it is not a risk. DS explained that the Trust was moving to secure a programme; this had not worked in the past.

- GW suggested considering risk appetite and suggested adding a risk tolerance column to the report; CS advised that this will be picked up at Board Development by an NHSi expert.

- SB felt that articulation of some risks is poor, citing risk 2640 as an example – mitigation was listed as 'Deputy Director of Nursing informed', which was not appropriate mitigation.

The Board noted the Corporate Risk Register

STRATEGIC

209/19 17. STP UPDATE

The Board noted the STP reports

REGULATORY AND GOVERNANCE

210/19 18. REGISTER OF DIRECTORS' INTERESTS

The Board noted the Register of Directors' Interests

211/19 19. GENERAL ELECTION GUIDANCE - PURDAH
The Board noted the Purdah guidance and the Trust's compliance

PERIODIC REPORTS

212/19 20. WHISTLEBLOWING

The Board noted the Whistleblowing report.

GW was disappointed that no issues had been raised with the FTSUG; he expected to see several. CC advised that this report relates to October; the FTSUG is actively involved with whistleblowing and is working closely with HR.

FS suggested that if managers are actively engaged with staff, they would be able to raise issues directly.

The Board noted the Whistleblowing Update

213/19 21. RESEARCH & DEVELOPMENT UPDATE

The Board considered the report and discussion included:

FS advised that the Trust achieved its first commercially sponsored trial; a member of QEH staff is a key investigator.

The Board noted the Research & Development report

214/19 22. GUARDIAN OF SAFE WORKING REPORT

The Board considered the report, and discussion included:

- ZB presented reports for 2 quarters.
- There were 27 exception reports received in Q1 – 21 related to overtime.
- 2 exception reports related to safety concerns - 1 concerned inadequate cover for stroke services but ZB felt this was an isolated incident; 1 concerned training.
- Exceptions in Q2 relate primarily to trauma and orthopaedics; there was nothing reported from Obs & Gynaecology and trainees are reporting increased support and improved behaviours.
- There has been a significant improvement in exception reports from Medicine.
- ZB was concerned as he felt there were insufficient trainees in Trauma and Orthopaedics – he has discussed this with Lucy Dennell who is revising the rota to address concerns. There will be a new contract from next week and this may have a positive impact.
- General Surgery and Urology also gave cause for concern, with no increase in the number of trainees. There is a new registrar in Urology and trainees feel more supported.
- In Surgery, staffing for out-of-hours, nights and weekends is a concern; a new rota should be beneficial.
- Safety concerns were raised when the locum consultant was not replaced when on annual leave; however, there is no documentation to indicate that any patient came to harm.

SB was pleased with the notable improvement in Obs & Gynaecology and Medicine.

FS advised that the issue with the locum consultant led to the implementation of the 'buddy ward' system. A Clinical Fellow has been transferred to Surgery in relation to the safety concern, and the Trust is recruiting additional fellows. The overall number of trainees is fixed; the Trust has used locums to bolster numbers but the team needs to expand.

SB felt it was useful to know where issues were and to track actions to avoid impacting patient care. The Trust must ensure trainees are supported.

MD / Chair of Quality Cmte

AB felt the report highlighted 'hot' spots but there was no sense of the additional hours worked. ZB confirmed that these were received; for example, in Surgery there are 3-4 hours per exception report, and 254 hours for the quarter.

IM was keen to gain assurance on issues raised - FS / IM to discuss outside the meeting.

The Board noted the Guardian of Safe Working report

215/19 23. BOARD OF DIRECTORS – FORWARD PLAN

The Board agreed its Forward Plan

216/19 AOB –

AB raised the issue of car parking, noting that that the car park is usually full after 10am. He was concerned that patients may miss appointments. DS acknowledged that parking was an issue, and that the Trust needed to explore alternatives such as incentives for car sharing and park-and-ride. The number of spaces has been increased by over 100, with an aim for a further 30. **DS will take a paper to HMB then to Board; to include options, costs and timescales.** **COO**

Questions

Sheila Young had noted many patients / visitors not washing their hands. She added that reception staff do address the issue but can feel threatened. SB noted her comments and thanked her for raising the issue.

Esme Corner raised the issue of noise at night on the wards; this often features in FFT comments. EM advised that this issue was being progressed.

Date of next meeting of Board of Directors (Public) meeting – Tuesday 4th February 2020 at 10am in the Conference Room, Queen Elizabeth Hospital

The Board resolved that members of the public be excluded from the remainder of the meeting, having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

There being no further business, the meeting was closed at 12.30pm