The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

Minutes of the meeting held Tuesday 27 November 2018 at 11.30am in the Inspire Centre at The Queen Elizabeth Hospital, King's Lynn

Present:

S Barnett (SB)	Trust Chair
J Green (JG)	CEO
I Harvey (IH)	NED
D Dickinson (DD)	NED
A Brown (AB)	NED
M Ashton (MA)	NED
D Thomason (DT)	NED
E Hardwick (EH)	Chief Nurse
N Lyons (NL)	Medical Director
R Jackson (RJ)	Director of Finance & Resources
J Wade (JW)	COO
K Charman (KC)	Director of HR
P Johnson (PJ)	CTO

In attendance:

M Martin (MM)	PwC – to observe
J Morris (JM)	PwC – to observe
N Hares (NH)	NHSI Improvement
L Carter (LC)	Staff story - Junior Clinical Director
E Atkins (EA)	Staff Story
D Chessum (DC)	Head of Communications and Engagement
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer – minutes

ACTION

CHAIR'S WELCOME

SB welcomed those present to the meeting, adding that he was delighted to join the Trust as the new Chairman.

INTEGRATED PERFORMANCE REPORT

116/18 1.QUALITY PROGRAMME BOARD (QPB)

The Board considered the report and discussion included:

- There have been 3 QPB meetings to date, forward – work is underway on assessing the QIP and the 5 workstreams are being led by the EDs.
- A number of actions are already 'red' – this is an indication of current operations rather than a reflection of the QIP. There are a number of recommendations to address these actions.
- The QIP was developed at an early stage and it is expected to evolve; it was acknowledged that some timescales are optimistic.
- The sign-off process will be between the Project Manager and the action owners.

- Actions will go through the assurance process – EH, along with staff and patient representatives, will ensure the action has the necessary impact to address the issue and can be evidenced.
- MA queried whether EH could clarify the improvement cycle and methodology to effect changes – EH explained that the team were in the process of choosing a quality improvement methodology using the PDSA cycle but this needs to be part of the Quality Improvement Strategy, which everyone signs up to.
- IH sought an example of what will be looked for as part of the sign-off process – EH advised that, for example, in relation to DNACPR this would be sub-actions such as a change of policy or form, or the outcome from an audit. The action will not be signed-off until EH can see it is embedded. This will be tracked through the Quality & Performance Committee.
- SB recognised the importance of ensuring sustainable change rather than working to achieve a successful re-inspection. EH agreed, adding that it was important to involve frontline staff as they are likely to have ideas for change; these staff will also need support through the process.
- KC advised that a sustainable workforce is being reviewed by the Workforce Committee; the Trust has a high-grade unregistered staff cohort, which could be utilised to support registered staff.
- Cultural change is being supported by NHSi and HEE and will involve the development of a Change Team. This team will be open to all staff and will include interviewing senior management about their values compared to the organisation's values.
- SB observed that the Board needs to see sustainable quality improvement and change and as such all future papers must contain sustainability, so this can be tracked.
- The Board approved the QPB ToR.
- Plans are ongoing in relation to the winter period; the Trust needs to ensure it continues to offer safe services. The issue has generated a significant amount of interest both inside and outside the Trust and SB is keen to hear the views of the community and system partners. The priority is patient safety.
- The winter plan was presented to the Board in September and there have been a number of assurance meetings with partners as presented at OAG last week. NHSi visited to see winter assurance plans. There is a greater degree of detail and understanding with this year's plan, which was developed with staff in relation to working differently. There are implications for partnership working. The Trust will be using specific project manager support to develop plans and review all options for early December. The Board will review and agree the final plan.
- NL agreed that safety is the Trust's top priority, in relation to patients at the front door, inpatients and also patients on waiting lists – all must have safe care. The Trust also has a degree of responsibility for safety across the geographical area, i.e ambulance offload. He recognised that in order to provide safe staffing, the Trust must have sufficient staff but nurse recruitment remains an issue.
- The 5 options are:
    - to look at the front door to manage emergency patients effectively and, where appropriate, treat in the community;
    - manage flow through the hospital efficiently – do the right thing at the right time, ensuring patients are not in the hospital

any longer than necessary;
  - ensure patients have adequate support to leave hospital in a timely way by working with system partners, i.e community support;
  - working differently, e.g. maximising day surgery. Patients may be able to stay 23 hrs which could free up beds;
  - moving some surgery to neighbouring hospitals – in the interest of patient safety it would be irresponsible not to consider this option for winter.
- DD noted that these options refer to the short-term and queried actions relating to MFFD / long stay patients – NL advised that EH was working with external partners to facilitate discharge of these long term patients.
- EH advised that she was undertaking ward rounds with colleagues and community providers in relation to 'the stranded patient' (over 21 days) – they consider the reasons for continued admission and how they can support the Trust to discharge the patient. ECIST was also in the Trust last week and EH is meeting the team tomorrow for feedback.
- DT referred to option 5 and queried whether patient choice / discussions with consultants had been considered. NL advised that the options would only be a short-term measure across winter; patients would be offered a choice but NL felt that it would be irresponsible not to explore all options.
- AB queried how many MFFD patients were currently in the hospital - EH confirmed there were 75 MFFD patients. She had recently visited Stoke hospital and observed how they worked with partners differently – she is aiming to take this forward at QEH.
- **MA observed that the number had increased since the issue was raised at the last Public Board meeting – she noted that the Board had been updated on the process but asked EH for details of actions on a monthly basis along with a trajectory for reduction in numbers. SB agreed.** **EH**
- JG advised that DTOCs were also an issue for the Trust – the number should be c13 but is currently c30. He met with the Regional Director from NHSi on Friday to discuss the lack of engagement by Cambs in relation to social care; he received assurance that the issue would be a priority.
- IH referred to cancer performance and noted that the Trust is not meeting its 62-day target. Some patients are waiting in excess of 104 days and he queried what measures are in place to ensure patients do not suffer any additional harm. NL advised that the harm review process indicates there is no evidence of physical harm but he did acknowledge the additional stress caused by delays. He added a caveat that there is an element of patient choice in some of the delays, i.e patient holidays.
- MA noted that the IPR indicates poor C-Difficile performance and asked EH for processes / assurance – EH advised that an extensive deep-clean programme had taken place, including vaporisation, and some essential refurbishment. Cleaning capacity and training has been increased along with the level of oversight. Visibility of cleaning schedules is being developed. Hand-washing, use of PPE, and keeping away from the wards if staff / visitors are unwell are all vital tools for reducing IPAC issues. EH is working closely with NHSi and the matrons to improve leadership.

The Board noted the QPB update

117/18 2. QUALITY

The Board considered the report and discussion included:

- There was a national mandate to adopt NEWS2 by April 2019 and NL was pleased to confirm that QEH had implemented the system on 1st November. He felt this was an excellent example of unified working across the Trust.
- The management of SIs was identified by the CQC as requiring additional work and this is ongoing, including shared learning.
- All mortality indicators confirm that the Trust's mortality levels are in-line with expectations.
- NL acknowledged that the data on page 10 relating to avoidable deaths did not add up correctly – this is an issue with the national template and a new version is being released shortly which will resolve the issue.
- JG clarified that due to reporting changes in 12 hour breaches, patients requiring mental health beds / community support are now deemed to be breaches for the host organisation rather than the destination organisation. The Trust reported 2 of these breaches this month, both requiring external support.
- EH advised that the way PUs are reported has changed in line with new guidance. She is working with the CCG to ensure the review of PUs / falls is validated and in line with national good practice. The Trust reported 7 PUs this month.
- Targeted training on Waterlow assessments for 'hot spot' areas has been arranged to improve practice.
- The number of falls per 1000 bed days is under 5 and the Trust compares favourably with national data, with less than 1 fall with harm per 1000 bed days. Patient acuity and staffing levels remain challenging.
- Norovirus is currently prevalent in the Trust and EH is working to manage – there has been a plea to the public to avoid visiting the Trust if they are having any symptoms.
- Clinical indicators have shown some improvement.
- 6 detailed QI visits have been undertaken to date; EH is using internal / external peer assessors to review indicators relating to patient safety and quality. The results are being used to create ward development plans.
- Despite challenges, the Trust is getting good response rates for Patient FFT and the Trust is deemed as a favourable place to receive care. There has been some improvement in A&E responses.
- The delay in responding to patient complaints is unsatisfactory. The Trust needs to work on themes identified by complaints, one of which is the discharge process. Staff must discuss discharge arrangements with the patient / family on admission to avoid delays at the point of discharge.
- **IH noted the sharp increase in PUs caused by lapses in care – EH felt that this may be due to a change in reporting but will check.** **EH**
- MA felt there was a general theme of worsening performance in some areas and queried whether there was any assurance on compliance and how the issue was being addressed. EH felt the Trust needed to be clear on outcome measures, ensuring these are visible at ward level and track

why compliance is not happening.

- **SB asked that more evidence and assurance is included in exception reports and the IPR.** **CEO**
- The paper on staffing fill-rates was noted.

The Board noted the Quality update

118/18 3. OPERATIONAL PERFORMANCE

The Board considered the report and discussion included:

- Performance against the A&E 4 hour standard increased slightly in October but dipped in November. ECIST was on-site last week and the Trust has been given actions to implement, such as using a Streaming Nurse. Delays in discharge, with the increase in MFFD patients, are also impeding flow.
- QEH is a Type 1 A&E and was ranked 68th out of 135 nationally in October for performance against the 4 hour standard.
- The backlog of cancer patients has decreased from c70 patients to 40. A sustainable backlog would be 20 patients.
- The Trust is likely to achieve its cancer performance for November and remains compliant with 14-day and 31-day targets.
- The Trust inherited breaches for DEXA scans when it took over the service earlier this year; however, these are now under control and the Trust has achieved the target for several months.
- The challenging Stroke position has recovered and the Stroke Unit has regained its 'A' rating, being recognised as one of the best in country and in the top 2 regionally.
- The 18 week position deteriorated in October following the Board's decision to reduce elective capacity in order to support safe staffing. Mitigation includes offering choice outside the QEH with providers including BMI Sandringham, The Fitzwilliam Hospital and North West Anglia Foundation Trust.
- SB queried whether there was a financial impact from outsourcing elective work - JW advised that the work was being carried out at tariff rates so there was no additional cost to the Trust, only the loss of income.
- **The Board recognised the areas of good performance and felt staff responsible for delivering this should be aware that this is well regarded by the Board.** **CEO**
- **SB noted that the targets for the year were different to the trajectories and asked to see up-to-date information to the end of the financial year which can be monitored by the Board. JW to produce.** **JW**

The Board noted the Operational Performance update

119/18 4. WORKFORCE

The Board considered the report and discussion included:

- Positive performance in relation to:
  - Number of staff in post (excluding nursing);
  - Fast track recruitment;
  - Flu vaccination – just 4 staff short of the target for clinical patient-facing staff. The CQUIN is worth c£100k.

- Challenges remain in relation to:
  - Sickness – focus is on long-term sickness;
  - Appraisal rates - data will be monitored by the Workforce Committee going forward.
  - Mandatory training – performance remains flat.
- AB queried whether the breakdown of sickness by staff groups had revealed issues – KC confirmed it had, the Trust is aiming to reduce nurse sickness to 6% with the rest of the Trust at 3.4%. In some areas current rates are c.11%. A sickness rate of 6% for nursing would release 23 WTE staff.
- MA queried whether the vacancies for domestic staff had been filled – RJ is expecting this to be achieved by the end of December. The deep-clean on Shouldham ward is due to conclude shortly and this will release domestic staff back to the general team.
- **MA felt it would be helpful to see Model Hospital data in relation to the Trust's position with its peer group for care hours per day.** **EH**

Strategy Refresh

- It has been a year since this was approved.
- **SB noted that this strategy covers medium-term aims but the Trust's current needs are more immediate – he asked to see a plan to address these needs, along with a plan to monitor for assurance.** **KC**
- MA confirmed that the plan had been received at Workforce Committee.
- The Board approved the Strategy refresh.

<u>The Board:</u>

- **<u>noted the Workforce update</u>**
- **<u>noted the Recruitment Incentives</u>**
- **<u>approved the refreshed Strategy</u>**

120/18 5. FINANCE

The Board considered the report and discussion included:

- The Trust has made a control total loss of £3.3m in October, excluding PSF the October loss is £2.7m adverse to plan.
- YTD the Trust has made a pre-PSF loss of £20.1m, £8.5m adverse to the pre-PSF plan and £11.2m adverse to the NHSI control total.

- SB acknowledged the Trust's serious financial position and was clear that the Trust needs a strong financial recovery plan which does not compromise on services, quality and safety but manages public resources better.
- RJ explained that he is in discussion with the regulator and the deficit information will be published on Thursday. He acknowledged that £34.2m is a large percentage of the Trust's operating income.
- **SB asked for a more granular breakdown of the drivers of the deficit, including month/month and final year forecasting to identify what the final deficit is likely to be. This information should be at submitted to Finance & Activity Committee then escalated to Board to ensure actions are having sufficient impact. He was clear that the Board must see accurate forecasting.** **RJ**

<u>The Board noted the Finance update</u>

121/18 Governor Questions

- P Tasker queried whether additional GP support for A&E, provided by the CCG, is continuing and if so, could this be promoted. JW confirmed that the service will continue – previously primary care streaming had seen 10-15 patients per day but this had now increased to c30 patients per day. He added that the service was a mechanism to manage the volume of patients in A&E and he did not want to encourage patients to use A&E instead of their own GP.
- P Tasker referred to the potential 23-hour day cases and queried how these patients would be managed if they returned home and became unwell - NL advised that some may be admitted to the hospital and work was underway to identify potential beds for this scenario. The Trust would also consider telephone advice.
- P Kunes queried nursing fill rates in excess of 100% - EH explained that this was due to a change in acuity of patients and the number of beds in some areas. The number of beds had reduced in some areas but had been re-opened occasionally. The minimal staffing level is flexed according to the needs of the patients / organisation.
- J Dossetor recognised that further work was required in relation to avoidable deaths – NL advised that the lack of a national definition made declaration a challenge. He added that the Trust is always learning from deaths but is struggling to categorise any element of avoidability.
- N Tarratt noted the recruitment incentives and queried whether there was anything being offered in relation to retention. MA agreed that the Trust needed to be more inventive on retention and the Workforce Committee has asked for increased pace and grip. KC advised that there had been some reduced turnover and she was asking staff for additional ideas. She felt that financial security is important for staff and the Trust is bringing in some financial services to help existing staff. RJ advised that there had been an STP discussion on training additional staff – it was felt that if staff train here, then they are more likely to stay. SB noted that there is an emphasis on exit interviews but suggested that the Trust should ask staff on day 1, what would encourage them to stay.
- **S Clark observed that there were incentives aimed at new staff and queried what could be offered to existing staff who often feel marginalised – MA advised that the Workforce Committee will canvas some ideas from the EDs in relation to this.** **KC**
- B Lewis referred to the lack of engagement by Cambs in relation to their super-stranded patients and queried whether this related to social care - EH advised that she was working with nursing and Health & Social Care partners to ensure patients who return to Cambs are not delayed unnecessarily. Issues relating to home IV treatment are being addressed with WN CCG / NHSE.
- E Corner noted that few of the plans being circulated had timelines or outcomes and asked the NEDs how they could take assurance that these plans are successful. AB felt that the Board needed more detailed plans – SB agreed, adding that he had discussed the issue with executive colleagues and future reports must include owner names, dates and evidence. IH felt that the implied timeline is the date of the next CQC inspection and the Board should take assurance from the QPB.

- R Broke felt the Trust should consider alternative options to address delayed discharges; he suggested SB liaise with the local hospice, which could have a number of available beds. SB advised that in Hertfordshire hospices let the hospitals know how many available beds they have each day.

Public Questions:

- One gentleman advised the Board that if services were transferred to Norwich, even temporarily, local patients would struggle to get there on public transport. SB acknowledged the challenge but was clear that transfer of services was only one of the options being considered.
- Another question related to patient safety and queried how the Trust can guarantee this if sick patients were required to travel 50 miles to NNUH which itself is overstretched and rated inadequate by the CQC. An additional suggestion related to asking existing staff why they stay at the Trust and then aiming to replicate this on each ward. SB felt this point was really important – the Trust needs to encompass the view of staff and why they stay. Patient safety is the Trust's top priority and the Board will consider public concerns seriously.
- A member of staff queried where the revised deficit places the Trust in the national table - RJ advised that the national table will not be available until Thursday but he acknowledged that the Trust will be a national outlier.
- SB observed that this would be the last Governors' Council meeting for some governors and he was sorry that he would not get to know them as well as he would like. He thanked them on behalf of the Trust and the community they serve. He wished those standing again 'good luck' in the forthcoming elections.

6. CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE

SB welcomed the Board to the second part of the meeting.

122/18 7. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 25TH SEPTEMBER 2018 / MATTERS ARISING

The minutes of the meeting held on 25th September were considered to be an accurate record of the meeting

123/18 8. ACTIONS MONITORING

The Board reviewed and updated the Actions Monitoring Record.

Actions 07, 11, 12, 28, 34, 37, 38, 39, 40, 41 and 42 were considered complete and were removed from the action log.

Action 41 – investigation following Patient Story

The investigation should be complete next week. MA was disappointed with the length of time this has taken; KC agreed and suggested there should be KPIs for investigations. **KC / EH**

GR suggested changing the action to ensuring the Board is made aware of the

learning from the investigation.

CEO

SB was disappointed with slipped actions; he felt that dates should be achievable and progress boxes should be completed in advance.

See Action Log for further updates.

124/18 9. DECLARATIONS OF INTEREST - none

125/18 10. URGENT ACTIONS (Under Standing Order Para. 5.2)

a. **Loan Request**

The Board approved the Loan Request Urgent Action

126/18 11. CEO'S UPDATE

The Board considered the report and discussion included:

- JG advised there was a typographical error on page 1, 3rd row from bottom – this should read "we do not….".
- Issues relating to patient safety and CQC improvements were discussed earlier in the meeting. The Trust is making reasonable progress but needs to improve pace and include more granular detail.
- IPAC – the deep-cleaning programme was been successful although it has taken longer than expected. This will be repeated in spring / summer 2019. Norovirus has been prevalent in the Trust over the last few weeks and this has proved challenging.
- Flu vaccinations – the Trust achieved a very strong performance against the target last year, placed 13th in the country; JG was delighted that performance is ahead of that this year.

The Board noted the CEO's update

127/18 12. CHAIR'S REPORT

The Board considered the report and discussion included:

- This was SB's first report and he advised that future reports will contain more external information, including national updates and policy updates which are relevant to QEH.
- He was amazed and grateful for the incredible effort made by Gavin English who raising £50k for the Trust and is arranging to meet him to congratulate him personally.
- SB will write to congratulate all staff who passed exams recently.

The Board noted the Chair's Report

STRATEGIC

128/18 13. NORFOLK & WAVENEY STP update

The Board considered the report and discussion included:

- JG advised that the main focus has been on winter resources and a mental health review.
- SB has spoken with both Patricia Hewitt [STP Chair] and Melanie Craig [STP Accountable Officer] about how QEH can play a more significant role in shaping the STP, particularly the integrated care pathway. Both colleagues have agreed to attend a future Board Development session. The Trust needs to be involved in the decision-making process.
- AB referred to point 12 and queried whether there was a 'winter room' in place in the Trust to support the plan - JW confirmed there was.
- IH queried whether there was any service not being commissioned i.e IV at home – JG advised that there are services the Trust would like to see which are not commissioned or which the Community Trust is not able to provide. QEH is not where it would wish to be in terms of additional support but the Community Trust is also challenged in terms of resource.

The Board noted the STP Update

129/18 14. HEALTH & WELL-BEING BOARD STRATEGY

The Board considered the report and discussion included:

- AB noted the ageing population and its potential impact on admissions. By 2022 the system could see a net increase in admissions equal to 90 additional wards / 4000 staff – AB was concerned that there was nothing in the plan to address this and felt it was not a sustainable plan.
- NL agreed but suggested the required provision may not be wholly hospital beds.
- PJ advised that there is a STP workstream addressing this – the Boston Consulting Group undertook a review and is due to report in December.
- IH felt the plan provided a description of problems and associated aspirations but lacked actions.
- SB felt the plan assumes resource can be moved out of expensive acute settings and into a community resource.
- **The Board endorsed the strategy; however GR will contact the Health and Wellbeing Board to advise of the Board's concerns.** **GR**

The Board endorsed the Health & Well-being Board Strategy

QUALITY

130/18 16. STAFF STORY

Lauren Carter and Ellie Atkins are respectively a junior doctor and registrar and Clinical Directors (CDs), and they attended to inform the Board about their dual roles.

- NL advised that the Trust now has 11 CDs, recognising that there are significantly more doctors who are not consultants.
- Lauren graduated 2 years ago and has been working at QEH since then, rotating around most departments. She joined the Local Negotiating Committee (LNC) and chaired the Junior Doctors' Forum before being

asked to take on the role as CD.

- Ellie is a 4th year surgical registrar who joined the Trust this year, having previously worked for BUPA.
- Lauren spends 3 days a week in a clinical role and 2 days as CD; Ellie spend ½ day in the CD role.
- NL queried how fellow clinicians felt about the new roles. Lauren felt that as a group the clinicians were quite hierarchical - some accepted the role quickly whilst others took longer but she persevered and provided a voice for junior doctors. She voiced her ideas to address challenges of working at the Trust and believes her CD colleagues now see her as more of an equal.
- NL advised that Lauren was highly efficient when the Trust is in Internal Incident – she coordinates medical outliers, making sure junior and senior doctors to see them. She works with doctors on the wards to ensure they consider which patients should be admitted and which could be managed at home with a follow up in clinic.
- NL advised that the QIP identified the need to improve the quality of medical notes so Lauren joined the Medical Records Committee where areas for improvement were identified following an audit by a non-clinical team. Lauren has taken the proforma and considered it from a clinical perspective; she has ensured that questions are now more clinically relevant so the audit can identify where doctors are providing good care, and the records themselves are documented in a way that any doctor easily identify the treatment plan. There is still work to be done but there has been good progress.
- NL queried whether this role has encouraged Lauren and Ellie to take on leadership roles in the future – both confirmed it had.
- NL thanked both CDs for attending; he added that both will be showcasing their achievements at a national conference shortly and will write a paper to highlight how their role can be important in a small DGH.
- IH queried whether Lauren was working with doctors on exception reporting. Lauren advised that she was the union representative for the BMA and is involved in junior doctors' inductions; she is committed to encouraging them to complete exception reports and the number is gradually increasing.

The Board noted the Staff Story

131/18 17. REVISITING THE PATIENT STORY

The Board considered the report and discussion included:

- This was an update from the patient story in September.
- Work in relation to the action will be undertaken during Q4 and Q1. The Lead Nurse for older people and the Deputy Director of Nursing are working with wards, particularly in relation to outlying patients / surgical patients with dementia.
- MA queried how EH will know these actions have made a difference - EH advised that response from staff on training and patient feedback should inform her as to whether the actions have been successful.
- SB reiterated that the Board must see evidence of impact in reports.

The Board noted the Patient Story update

RISK

132/18 18. CORPORATE RISK REGISTER (>15)

The Board considered the corporate risk register and discussion included:

- NL advised that significant work was on-going with NHSi support to review the risk process, including quality, consistency and time limits. He added that the quality of the register will improve by the next submission.
- There are 3 new risks – 2 relate to staffing in midwifery and 1 relates to security on Rudham ward, where there has been two incidences of children absconding.
- SB noted that some risks have become issues, i.e. finance, and these need to be removed.
- **The NEDs asked for additional details relating to the 2nd incident on Rudham ward.** **NL**
- Risk 2459 relates to access to Rudham and MA queried the mitigation - NL advised that the time-delay on the door has been reduced to 2 seconds rather than 5. JW added that although it is not possible to install double doors, a hatch is being installed so the ward clerk can view those entering and leaving the ward. The decommissioned fire escape at the rear of ward will be blocked up. The risk was previously under-scored but is now an accurate reflection.
- SB reminded colleagues that any information submitted to Board must be accurate.
- **MA felt that the issues on Rudham had been on-going for too long in terms of risk and incidents and queried whether there is a completion date for the works. She felt there was a lack of assurance for such a high risk area – she requested details within 24 hours.** **JW**
- DD observed that the risk registers are reviewed at Risk Committee, which has no NED presence, then submitted to Board; he felt that there should be outcomes, actions and timescales. He suggested the registers needed to differentiate between operational and strategic risks.

The Board noted the Corporate Risk Register update.

REGULATORY AND GOVERNANCE

133/18 19. PERIODIC REPORTS

a. Guardian of Safe Working update

- NL advised that this was a statutory report with defined headings.
- There is a new GOSW in post.
- Exception reporting is significantly higher than other benchmarked trusts, which is considered beneficial as it identifies issues.
- SB reminded NL that the Board needs assurance that oversight is achieving the necessary results.

b. Research & Development update

- This is a regular report.
- NL felt that the R&D team is 'punching above its weight' and praised the team for their hard work. He will continue to support the team

through the next few years in terms of centralisation.

- DD felt the report was positive and passed on his congratulations to the team.
- IH referred to centralisation and felt that it would be beneficial for patients to be recruited into trials. NL added that it was good for staff as well; however, recruitment was a challenge.

c. Fire Report

- RJ advised that the report has not yet been to the Health & Safety Committee. Actions will be addressed going forward.
- AB was pleased to note that the Board is compliant with training but concerned that 40 areas are non-compliant. RJ advised that training requirements had changed from 3 years to 2 years. The Fire Officer is now taking training to the wards and some parts can be carried out on-line. SB queried why the target is not 100% - KC explained that this is due to the availability of training and staff, as well as sickness and maternity leave. Overall compliance for mandatory training is 86%.
- MA queried when mandatory training will be aligned with pay progression – KC advised that this should take place next year when it will be aligned with appraisals. Failure to complete mandatory training means that staff will not receive their pay progression. Details will go to Workforce Committee. Medical staff are not eligible for a CEA if they have not completed their mandatory training.

d. Cyber Security update

- The Trust is in the least mature group nationally in terms of cyber security. Two other acute hospitals in the STP also feature in the bottom 5 nationally and a need for joint working has been identified. NHS Digital may be able to provide some support.
- PJ is meeting with the CIO from NNUH next week. He is also CIO for the STP.
- Some areas need short-term action but the department cannot identify an internal resource and recruitment has been unsuccessful.
- DD referred to the recruitment challenge and queried whether the Trust could consider joint working with other public sector organisations - PJ felt this could be considered.
- **MA suggested this should be a regular item on the Board agenda – it was raised at a national NED event last week**. **PJ**
- AB was supportive of the idea of joint working. He was concerned that 25 high-priority actions remained outstanding.

The Board noted the periodic reports

134/18 20. REGISTER OF DIRECTORS' INTERESTS

The Board noted the Register of Directors' Interests

135/18 21. BOARD OF DIRECTORS – FORWARD PLAN

The Board noted the Forward Plan

Date of next meeting of Board of Directors (Public) meeting – 29th January at 11.30am in the Inspire Centre.

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 3pm.