The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

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

Present:	
E Libbey (EL)	Trust Chair
J Green (JG)	CEO
I Pinches (IP)	NED
I Harvey (IH)	NED
M Ashton (MA)	NED
D Thomason (DT) *part 1 only*	NED
E Hardwick (EH)	Chief Nurse
N Lyons (NL)	Medical Director
R Jackson (RJ)	Director of Finance
J Wade (JW)	Director of Strategy & IT
K Charman (KC)	Director of HR
In attendance:	
S Jones (SJ)	Deputy COO – *for C Moore*
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer – minutes
C Hinton (CH)	NHSi
B Carey (BC)	NHSi

		ACTION
INTEGRATED PERFORMANCEORMANCE REPORT		
21/18	**1. QUALITY**	
	The Board considered the report and discussion included: • EL invited NL to comment on recent press articles relating to falls at QEH – NL advised that there were 2 SIs relating to falls, one of which took place on Leverington escalation ward in February and resulted in a patient death. NL expressed his sympathy for the patient's family.It was observed that as the investigation is underway it would be inappropriate to comment further until the results are known. • The other SI related to a fall on Elm ward where the patient sustained a fractured neck-of-femur. • EH explained that the Trust had seen a significant increase in cases of C.Difficile over the last 6 weeks and had declared an outbreak – NHSE, Public Health England and the CCG have been informed. Deborah Adams [Infection Control Lead at NHSi] visited the Trust yesterday and provided helpful confirmation of areas for improvement, particularly environmental / equipment assurance and antimicrobial stewardship. **Executives to take forward – EH to update.**	**EH**

	• MA queried whether EH felt the IPAC issues were related to staffing levels / non-compliance with practice or were broader and related to cleaning practices / facilities / environment. EH felt that there was an element of non-compliance, particularly during periods of high activity when temporary staffing levels are high. MA requested details of an improvement plan - EH will be working with the cleaning team from an IPAC point of view, ensuring adherence to the cleaning code, and she will be engaging external colleagues for a peer review. **An action plan for cleaning, both in the short-term and in the medium / long term – to include accurate cleaning standards – will come to Board in May.** EH is putting an extra resource into her senior team to ensure increased oversight. • IH noted that the Trust had experienced an outbreak in the autumn and queried what lessons had been learnt - EH advised that there had been some recurrent themes with no new issues being highlighted. NL referred to the antimicrobial challenge and suggested there was a need to modify the behaviours of individual doctors in relation to use of antibiotics; however, this is difficult with sepsis treatment. Work is ongoing with NNUH to improve antimicrobial support across acute trusts and within the community. • **IP noted that the report provides details of proposed actions; however, he sought clarity on how these would be incorporated in the plan. EH to discuss with IP outside meeting.** • **EL asked IH to continue to monitor the issue at Quality Committee.** • IH referred to falls at the Trust and whilst he agreed that recent tragic events should be taken seriously the trend data on page 11 of the IPR indicated a largely 'flat' falls performance and suggested seeking a longer-term trend. • EH advised that a Falls Summit took place at the end of February and this had proven successful. A further summit will be arranged for later in the year. The National Inpatient Falls data has been returned - a multi-disciplinary team is reviewing the results and the Trust is working on all nationally-recommended actions. • EL noted the Leverington action plan in the report and sought assurance that this plan will address current outstanding issues and be in place by the end of April - EH advised that the plan provides a framework for work. She is meeting the ward matron / sister on a weekly basis, providing assurance on quality metrics and the action plan. The Executive team recognises the need to close the escalation beds as soon as possible as it places the organisation under additional operational pressure. • DT noted that the 2018/19 budget will have to include the use of Leverington ward - JG advised that although Leverington appears to be closed for 4 months, during this time it will be fully operational as a decant ward whilst the other wards are deep-cleaned. It will be open as a fully-established ward when needed for escalation. • DT observed that the risk report contains reference to staffing on Leverington and reminded the Executives that the Board needed to be assured that this plan will be delivered in terms of supporting the workforce and managing patient flow. Governor Questions:	**EH** **EH / IP** **IH**

	• Anne Compton queried what happens to staff when Leverington ward is closed – EH explained that Leverington will become a vacant space so a whole ward will move there. Anne noted the recent substantive recruitment to Leverington, which had been reliant on a high number of agency staff, and queried whether this was a result of the catastrophic fall. EH explained that an escalation area is often reliant on a temporary workforce and in early December nurses were rotated from other areas to make up a baseline workforce – this was then 'topped up' with agency staff as appropriate. At the end of January / early February some staff were transferred back to their original ward, there was a high level of staff sickness and patient acuity was high – EH reviewed the number of staff on the ward on a day-to-day basis, increased the number of registered nurses and agreed to increase the number of substantive staff based on the ward for 6 weeks. Use of the ward is likely to continue until after Easter. • Malcolm Bruce queried whether Leverington would revert to being a surgical pre-assessment area - JG advised this was unlikely; some ad-hoc processes are currently in place for surgical admissions and Surgery division has been asked to explore the potential for alternative locations. Currently the Trust is seeing a low level of elective activity. • Hilary de Lyon voiced concern relating to the emergency c-section rate and recent Serious Incidents relating to maternity - NL acknowledged that there are some issues to be addressed, but whilst the c-section rate appears high, the forceps / instrumental delivery rates are low. The Trust is not alone in experiencing higher c-sections rates but the Executive are monitoring the situation and providing the unit with support. Badgernet is being used to ensure notes are transferred with the patient. Safe staffing • Recruitment and retention is crucial for a sustainable workforce and work remains on-going. All nurses who leave the Trust have a compulsory offer of an exit interview – this is an opportunity to persuade them to stay on at QEH but also allows the Trust to gain vital information to decrease the exit rate. **The action plan will go to the Workforce Committee.** • MA was pleased with the report but felt it failed to address the strategic plan for the next 3-5 years, identifying transformational ideas to get the right people in the right roles. KC felt this was a corporate responsibility following the implementation of the Workforce Strategy last year; currently she is working on refreshing the strategy, reviewing roles to ensure the right skill mix on the wards. **The Strategy will go to Workforce Committee later in October before being brought to Board in November.** • IP felt the report summary did not provide a sense of whether the Trust is operating safely – it contained data but not an informed opinion. • IH queried whether current staffing levels are safe and whether the Trust is equipping staff with appropriate access to IT systems - EH advised that day-to-day monitoring / mitigation takes place to ensure	**KC** **KC**

	the safe staffing minimum level is achieved; however, occasional short-term sickness may means that further mitigation is required and while there may be some delays in fundamental care, safe care in relation to medications is a priority. She acknowledged concerns due to the number of nurse vacancies but could not extrapolate direct correlation to falls / pressure ulcers. **The Board noted the Quality update**	
22/18	**2. OPERATIONAL PERFORMANCE**	
	The Board considered the report and discussion included: • IH referred to the Urology (Prostate) and Lung Transformation projects run by Macmillan West Norfolk and Norfolk & Waveney STP and queried what difference this will make to patients. SJ advised that patients should see a shortening of the early part of the pathway, with an early diagnosis. A one-stop clinic has been established on Feltwell ward and clinicians are reviewing all patients in advance to ascertain what treatment they may need on the day of their appointment, allowing them to advise patients on their predicted length of stay. **IH asked for more details on patients who have waited over 62 days –SJ to circulate the data outside the meeting.** • EL sought assurance that no patient harm was occurring in relation to patients exceeding the 62 day standard - NL advised that if a patient has an abnormal chest x-ray the Trust is no longer asking the GP to request a CT, this is now made directly, saving 10 days. A comprehensive review of the breaches is underway to understand how to change the process for the future. • IP voiced concern in relation to the decline on all 3 indicators for cancer and sought a timeline for improvement - SJ advised that the Trust is forecasting an improved position, expecting to achieve target in April; however, the service remains fragile. As the Trust treats low numbers of cancer patients, even a shared breach with tertiary partners can impact performance. The backlog of patients waiting has reduced from 26, with an aim of c15 patients. JG added that whilst not complacent with current performance, failure to achieve the standard is not an indicator of issues in the pathway. • EL queried whether the Trust was prepared for any additional pressures presented by the approaching Easter bank holidays - JG confirmed it was, with increased focus on discharge ahead of the weekend and staffing levels being reviewed. It had been hoped that the escalation beds could be closed during March, but demand had continued, and the beds remain in use. • IH noted that there was no data provided on ambulance handover – SJ advised that performance had improved despite significant challenge and QEH is in the top half of the table of local trusts. Communication with the ambulance trusts has improved. **SJ to circulate ambulance data outside the meeting**. Governor Questions • J Dossetor queried whether primary care streaming was working as expected - NL advised that the service is generally working well,	**SJ** **SJ**

	although it is challenging to predict demand. Primary care practitioners include senior nurses. **<u>The Board noted the Operational Performance update</u>**	
23/18	**3. FINANCE**	
	The Board considered the report and discussion included: • EL sought assurance that the Trust was taking all necessary steps to achieve the planned deficit by the end of the year, and whether lessons had been learnt going forward. RJ confirmed that the Trust was doing everything possible; however, patient acuity levels had decreased in March which was reflected in the reduced income level. The Trust has been clear with regulators in relation to slippage due to winter pressures. • IP sought assurance in terms of cash flow requirements for year-end and moving forward - RJ confirmed cash flow is in place for 13 weeks ahead, although it is more challenging at year-end, adding that the Trust is expecting to receive winter pressures funds. He acknowledged that the Trust is not where it would want to be in terms of paying suppliers. • MA challenged how the executive team triangulated the issues of finance, quality and activity - RJ advised that safety was paramount and cited premium payments to bank staff as an example. • MA queried whether longer-term plans were in place – RJ advised that there will be shortfalls in substantive staff so the executive team is considering options such as bonus schemes. There will be gaps even after substantive roles have been filled and these have been included in the financial planning. MA felt the Trust needed a staffing plan for the next 3 years – EH advised that immediate actions have included weekly pay for bank staff and premium pay for bank staff. • IP noted that at Finance & Performance Committee this month, a challenge was raised to the executive team in relation to the budget for next year as volume numbers were not supported by the draft budget – he queried how the Trust was planning for the next 3-5 years. RJ advised that the budget was based on the draft submission and this will continue to be reviewed until the end of April; planning for Leverington remains ongoing. The Trust will align the plan at the final submission. • JG acknowledged the requirement for a longer term workforce plan, and noted that the Trust is still developing its 3-5 year financial plan. The Trust is working with system partners to evaluate future service provision but the current position is not where it would wish to be. He suggested completing this year and setting up next year before moving onto a 3-5 year plan, including model hospital and how the Trust will work differently. **This plan should be available by early summer.** Governors' Questions • A Walder sought assurance that the Trust will not be in the same financial position next year - JG advised that the Trust will be in a deficit position next year as it has a deficit plan; however, it will be demonstrating clear control of costs and has a clear plan on delivery of activity. The CIP programme is well established and is delivering,	**CM**

	including a contingency. There remains some concern on activity – the current emergency level has depleted elective activity but plans with the CCG will help the Trust to deliver. • A Walder queried how assured the NEDS were - IP advised that there had been considerable NED challenge on content / budget and they were currently satisfied that the right processes are in place. The NEDs are also taking some reassurance from RJ and JG in relation to outstanding work. DT confirmed that the NEDs were better-sighted this year, receiving month-by-month outlines, although there are still concerns regarding the level of delivery in the CIP plan. **<u>The Board noted the Financial update</u>**	
24/18	**4. WORKFORCE**	

	The Board considered the report and discussion included:
	
	• KC advised that mandatory training compliance has improved.
	• Staff survey results demonstrate no major change from last year.
	• The areas where the Trust scores were in the top 5 in country included:
	  ➢ Percentage of staff reporting most recent violence;
	  ➢ Percentage of staff agreeing that their role makes a difference to patients / service users;
	  ➢ Staff satisfaction with the quality of work and care they are able to provide;
	  ➢ Staff satisfaction with the level of responsibility and involvement;
	  ➢ Staff motivation at work.
	• The areas where the Trust scores were in the bottom 5 in the country included:
	  ➢ Percentage of staff reporting violence from patients, relatives or public over the last 12 months;
	  ➢ Percentage of staff reporting violence from staff;
	  ➢ Effective team working;
	  ➢ Percentage of staff experiencing discrimination at work;
	  ➢ Quality of appraisals.
	
	• KC felt these results were indicative of the challenges the Trust is facing.
	• KC has visited the wards to talk to staff about physical violence they may have experienced – this was seen as a result of complex / confused patients. No staff acknowledged violence by other staff but KC felt that as 2% had declared this, she would be attempting to secure more details.
	• A number of surveys have been carried out looking at staff behaviours and an action group has been established. The information is now being put into a behavioural framework which will be cascaded to individual managers.
	• MA was satisfied with the work programme being undertaken by the Workforce Committee. She noted reported communication issues between staff and senior managers and queried what actions would be put in place to address this. JG acknowledged that there is work to be done; however, the Trust is still in the process of restructuring on a wider organisational level.	

	• EL referred to the gender pay gap report and felt the data suggested the Trust needed to recruit more female consultants. KC explained that the pay gap is most visible within medical roles; however, the Trust has seen significant growth in the percentage of women in medical roles, which should see the gender pay gap diminish with time. • MA queried whether any benchmarking was available – KC explained that all trusts will be required to upload their data and this will allow benchmarking. To date, some hospitals have uploaded data and QEH is situated mid-table. **Full details will go to Workforce Committee when available.** Governor Questions • J Brodie queried whether new staff were having dementia training - KC advised that it was covered briefly during induction for all staff with bespoke training provided for nurses / AHPs and staff on geriatric wards. Alison Webb, Lead Nurse for elderly care, will be offering more training as required. • S Clarke referred to physical violence for staff and felt that not all violence could be attributed to dementia patients. He queried whether KC could find further information within specific departments – she explained that she could not report confidential information but acknowledged that the Trust needed to find alternative reporting methodology for staff. He noted within the report that staff had reported harassment by other staff, citing general management and Finance with 13 and 20 staff respectively reporting harassment. KC advised that the bullying survey had identified 5 specific areas and HRBPs were working with staff and managers in those areas. • B Lewis queried how quickly 'return to work' interviews were carried out – KC advised that these usually took place on the first day of returning to work with either the line manager or OH, but she acknowledged that this did not always take place and it will be audited. The new focus on sickness absence is about preventing absence, with an emphasis on health & well-being. • H de Lyon noted that the Trust is not fully compliant with its statutory mandatory fire training - KC explained that the Trust had changed its rules on fire training, which is now due every two years rather than the previous three years. She added that the training is on a steep trajectory for recovery. **<u>The Board noted the HR update</u>**	**KC**
GOVERNORS' QUESTIONS		
25/18	See above	
QUALITY		
26/18	**5. CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE**	

	EL welcomed the Board to the second part of the meeting. He thanked the governors for their participation and welcomed Claire and Brendan from NHSi who were present at the meeting in an observatory capacity. Apologies were received from C Moore, D Thomason (part 2)	
27/18	**6. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 30th JANUARY / MATTERS ARISING**	
	The minutes of the meeting held on 30th January were considered to be an accurate record of the meeting.	
28/18	**7. ACTIONS MONITORING**	
	The Board reviewed and updated the Actions Monitoring Record. Actions 17, 28, 31, 32 from 2017 and 01, and 03 from 2018 were considered complete and were removed from the action log. **See Action Log for further updates.**	
29/18	**8. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA**	
	None	
30/18	**9. URGENT ACTIONS (UNDER STANDING ORDERS PARA 5.2)**	
	a. Short Term Loan • The Board noted that this had been signed-off on 5th March. • RJ provided confirmation that the Trust had met the terms and conditions of the loan – this assurance will be included with each application. **The Board approved the Urgent Action in relation to the Short Term Loan.**	
31/18	**10. CEO'S UPDATE**	
	The Board considered the report and discussion included: • JG noted that QEH remains under pressure along with the NHS as a whole. Actions in place to address these pressures have been documented. • Since the last meeting Norfolk had suffered inclement weather and snowfall and JG thanked staff for traversing often hazardous conditions to arrive for work at QEH. He also praised RAF Marham who provided support by bringing staff in from more remote locations in 4x4 vehicles. • JG had given several CQC presentations to staff, keeping the message positive and encouraging staff to be open, honest and above all, proud when speaking to inspectors. • The STP was not successful in its bid to become an ICO but has been	

	included on the 'early adopter' list and will be considered again in the latter part of 2018. • There has been a change of portfolio for CM and JW – JG thanked both for the work they had carried out and wished them every success in their new roles. • EL noted JG's CQC presentations and queried how he planned to communicate the message to staff who had been unable to attend the briefings - JG explained that he would be taking the message to those staff and the Executive team are planning to visit the areas where staff would struggle to attend. **The Board noted the CEO's update**	
32/18	**11. CHAIR'S REPORT**	
	The Board considered the report and discussion included: • EL referred to the television coverage of the recent Oxford / Cambridge boat race and observed that one of the rowers had trained as a doctor at QEH. He felt the Trust should be proud of the quality of its trainees and asked NL to pass the Board's congratulations on to his colleagues. **The Board noted the Chair's Report**	
QUALITY		
33/18	**12. PATIENT STORY**	
	CR introduced Dr Keith Redhead, a retired GP from King's Lynn, who shared his experience as both a patient and as a GP. • Following a meal with friends Keith experienced sharp abdominal pain, which worsened over the following hours and moved to his loins. Keith described the pain as being the worst pain he had ever experienced, causing him to vomit. At 1.30am he could take no more and woke his wife who rang 111 and following a telephone triage an ambulance arrived. Following routine observations Keith was offered IV morphine and paracetamol; he arrived at A&E feeling vulnerable and in pain. • Keith was suffering from renal colic. He was seen by a nurse at 3am who administered a Diclofenac suppository, reducing the pain considerably within 20 minutes. Keith was impressed that the nurse could offer this without waiting to see the doctor. • At 6am Keith was admitted to SAU where he saw a variety of staff who ensured there was no alternative cause of his pain. • He then moved to Marham ward and had a CT scan. His pain was easing and he felt more comfortable. The consultant showed Keith the x-ray and he could see the stone. • Keith then went home with a supply of Diclofenac and had a repeat CT scan 3 days later; the stone had not moved and was now causing swelling so would need to be removed. • He went to Feltwell ward and saw Mr Masheshkumar; he was then admitted to SAU before returning to Marham ward. Keith was seen by an anaesthetist and a locum Urologist. He went to Theatre at 9am where he was seen by a cheerful team who ensured he was fully briefed	

	on the operation. He woke up in Recovery before being taken back to Marham ward. He was able to phone his wife and found visiting hours to be reassuringly flexible. Mr Calleja came to see Keith and explained that the stone had been removed in one piece. • A pleasant nurse from the Discharge Lounge came with a wheelchair to collect Keith but he felt able to walk. • Keith was complimentary about several aspects of his care, including: ➢ clear communication by staff; ➢ access to radiology; ➢ the ambulance crew; ➢ the explanation of the procedure by the consultant team; ➢ conversing with friendly, multi-national nurses; ➢ pain-relief; ➢ the explanation of the admissions process; ➢ the excellent handover process. • He summed up by saying the process felt like a well-oiled machine. • Keith was impressed by the access to the radiology service on a Sunday morning, considering the service to be an essential diagnostic service. • The international team of professioalss working at QEH demonstrated care and respect to all patients and the staff seemed to enjoy working at the Trust. • EL was delighted to hear a 'good news' story and suggested it should be shared with the rest of the Trust. Keith advised that he had written 8 'thank you' letters to those involved in his care. • EH advised that she had visited Radiology last week with JW and KC – the department sees 98% of all inpatients and is a key part of the Trust's 'engine'. She added that the Trust has a very diverse workforce, which is committed to providing quality care and was pleased to hear Keith had received the level of care he wanted. • JG thanked Keith for taking the time to write in; his stay had taken place when the Trust was under extreme pressure. He personally signs all compliment and complaint letters and advised that the Trust receives 10 times as many 'thank you' letters as complaints. He felt it was good to remind staff what an excellent job they do, despite significant pressures. • IH queried whether Keith felt his status as a health professional, coupled with his medical knowledge, made the process smoother – Keith acknowledged that some of the older staff may have remembered him from his days as a GP but he was clear that he did not receive any special treatment. He added that he had been very impressed that all patients appeared to be receiving equally good care. • The Board thanked Keith for sharing his story. <u>The Board noted the Patient's Story</u>	
34/18	**13. REVISITING THE PATIENT STORY**	
	The Board considered the report and discussion included: • EH advised that a paper on delirium had been discussed at Quality & Safety Committee in March and that the lead nurse for elderly care is now focussing on this. • IH felt the delirium assessment tool needed to be more embedded in	

	initial assessments - NL is aware of the issue and advised it is being addressed. **<u>The Board noted the Patient Story update</u>**	
35/18	**14. QUALITY ASSURANCE AND CQC COMPLIANCE**	
	The Board considered the report and discussion included: • EL noted that the Trust is expecting an inspection imminently. • EH advised that significant preparation work is underway, including clinical reviews, as the Trust moves towards the unannounced visit. The clinical reviews have not identified any new issues. • IH queried pace on the action plan to address ASIs - JW advised that discussions are ongoing to see if the issue can be managed differently and improve patient experience, i.e. extend the range of appointments so patients can book further ahead. This will be decided by the end of next week. The other issue relates to demand / capacity and the volume of high acuity emergency patients seen recently - once winter pressures ease more resource will be available. • JG added that ASIs do not affect all specialties - JW advised that reviews have been introduced for high-risk specialities such as Cardiology, to ensure no harm occurs to long waiters. IH thanked JW for the assurance but noted that the report did not convey that message. • IP sought assurance that remaining outstanding policies will be addressed in April this year - NL confirmed this had been done. GR added that at TEC, NL had asked for the suite of policies to be aligned to ensure consistent advice / guidance. • **EL suggested that the Finance & Performance Committee review ASIs in May.** • **JW suggested long waiters could be tracked month/month and added to the IPR.** **<u>The Board noted the Quality Assurance / CQC Compliance planning update</u>**	**DT** **JW / CM**
RISK		
36/18	**15. BOARD ASSURANCE FRAMEWORK**	
	The Board considered the report and discussion included: • GR advised that the BAF has been updated. • Risk management is on the Board Development agenda for April. • GR advised that capital funding has flagged as a risk for the first time – see risk 5. RJ is due to meet the regulator in April to discuss. **<u>The Board endorsed the Board Assurance Framework (BAF)</u>**	
37/18	**16. CORPORATE RISK REGISTER (>15)**	
	The Board considered the corporate risk register and discussion included: • EH advised that significant work continues on the risk registers with	

	governance leads and has Risk Committee oversight. • There are currently 28 open risks rated 15 and above – the Risk Committee are reviewing articulation to ensure adequate mitigation is in place and scoring is accurate and consistent. EH met with Mark Rose, the new Deputy Director of Patient Safety, this week to discuss. • EL suggested focussing on ensuring risks are not duplicated. • EH advised that colleagues needed to manage their risks, ensuring correct mitigation, actions and oversight. She felt each risk should be considered in terms of being tolerated or addressed and score reduced accordingly. • IP was pleased to hear this as he had been concerned by the Trust's capacity to manage 28 high level risks. • MA suggested ensuring staff are not using the risk register as a form of problem solving. • IH noted that the register is grouped by division but suggested it could be grouped differently. KC advised that there are 4 actions plans to address nursing risks – these can be included in the Trust action plan rather than asking divisions to create 4 separate plans. • GR added that Datix reports can be 'cut' by division / department / theme / Executive. **The Board noted the Corporate Risk Register update.**	
REGULATORY AND GOVERNANCE		
38/18	**17. PERIODIC REPORTS – *None***	
39/18	**18. POLICIES – *None***	
40/18	**19. REGISTER OF DIRECTORS' INTERESTS**	
	noted	
41/18	**20. BOARD OF DIRECTORS – FORWARD PLAN**	
	The Board noted the Forward Plan	
	Questions • S Clarke felt the risk register comprised a series of issues rather than risks and had done for several years. JG advised that this was being addressed by increased risk management training. • J Dossetor noted that a risk relating to Radiology is now on the register. The service was facing an increase in waiting times due to capacity and staff feel under pressure – he queried whether the current establishment is sufficient to meet the increased demand. JG explained that an external review is due to take place and a Radiologist will use guidance from the Royal College in relation to job plans / reporting processes. An external radiographer will review patterns of work. This review is expected to take place in April. KC added that the service	

	needed to return to radiographer establishment; it faces 2 pressures – reporting and recruitment. Recruitment is taking place via Skype. For existing staff the service is ensuring protected breaks and will be visiting other areas who are addressing provision of a 24/7 service by shift rather than by extra hours. • J Brodie queried whether the Trust had an age limit on MRI provision – NL explained that the Trust does not have an age-limited service but there is best practice advice for each procedure. **He will discuss the issue with JB outside meeting.** • P Tasker sought more information on the use of Wire Safe - NL advised that wires are used when carrying out chest drains and could sometimes be retained – Dr Peter Young developed Wire Safe at QEH to prevent this happening and it is now being used nationally. • P Tasker asked if the NHS 70th anniversary celebration on 17th May was open to everyone - GR advised that all staff and governors would be invited, along with external partners and some alumni. Invitations would be issued very shortly. The Communications department are compiling an impressive archive of photographs. The event coincides with National Nurses week.	**NL / J Brodie**
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.		
Date of next meeting of Board of Directors (Public) meeting – 29th May at 10.30am in the Inspire Centre.		
There being no further business, the meeting was closed at 2.45pm.		