The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

Minutes of the meeting held on 30th January 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
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
S Chobrzynski (SC)	Interim Deputy Director of HR
E Corner (EC)	Lead Governor
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer - minutes

		ACTION
INTEGRATED PERFORMANCEORMANCE REPORT		
01/18	**1. QUALITY**	
	The Board considered the report and discussion included: • JG advised that the NHS as a whole was facing challenging times. Over the last 4 weeks the admission rate has reached 130% of the standard rate – this is the equivalent of two extra wards every 3 days. Attendances have remained at a relatively normal level but a larger number have required admission, many with flu symptoms. • A television crew had been in to film in the Trust 2 weeks ago and the show will be broadcast on 1st February. At the time of filming, 330 beds out of a possible 440 contained patients aged 70+; of these, 20 were over 100 years old. Acuity, flow and age are all challenges, along with maintaining safe staffing, high registered nurse vacancies and high staff sickness levels. • EH advised that the Trust had today declared an internal incident. • EH is proud of how staff have worked together, particularly those on the front line. She acknowledged that putting staff under pressure to deliver the best possible care was also impacting on staff health. • She was also proud that despite operational pressures many quality indicators had remained within acceptable parameters; however due to staffing challenges Ward Managers / senior nurses were included in nursing numbers so senior oversight has slipped and this was evident in	

some areas where programmed assessments had not been carried out in full.

- Some governors had taken part in the ward accreditation process – EH was keen to obtain a true picture of the Trust.
- NL echoed EH's comments in relation to the commitment and hard work of staff. He was impressed that staff had been able to report incidents despite the increased pressures, although there was no significant rise in Datix numbers and no trends relating to safety concerns.
- IP queried how the executives were supporting ward staff – EH advised that EDs were as visible as possible on the front line, that free coffee / biscuits were being offered weekly and that bank staff would be paid weekly rather than monthly from April. She is working with KC / RJ to incentivise bank working.
- KC referred to the high number of vacancies and felt that there was reliance on too few staff – as such there is a targeted campaign to attract more bank staff.
- At recent Behaviours Workshops, staff felt that being thanked by managers was at the top of their list of requirements.
- IH queried whether the logistic issues on Leverington had been resolved – EH advised that the opening / closing of Leverington had been a challenge, particularly from a nursing perspective. The ward has been full for the last 3 weeks and will be kept as an escalation area for the next 3 months. A Band 7 from Tilney ward will act as Ward Leader with a Band 6 acting up on Tilney ward. EH is rotating staff from other wards to support Leverington. The Trust needs to support staff, ensuring that their flexibility is explicitly valued. The continued use of Leverington has had an impact on the Admissions Unit – the organisation needs to support Surgery moving forward. Leverington now looks like the other wards, with a ward clerk, quality indicators boards, and a full complement of equipment; EH wants this to be a 'beacon' ward.
- EL queried how safety was being addressed – a senior nurse is allocated to check staffing levels each day, to identify gaps and move staff as appropriate. A tool is being used to record location of high acuity staffing will be balanced accordingly; this data is tested against other colleagues and the Site Team. This review continues at weekends, with senior staff and EDs using a 'Whatsapp' group for discussions.

Quarterly update on C-sections

- EH noted that based on snapshot data the Trust is performing relatively well in relation to C-section rates although there is an increase in elective rates, particularly for first-time births. EH felt it was important that intervention should be avoided where possible and that the O&G team should follow the same guidelines.

Governor Questions:

- Jonathan Dossetor advised that he had taken part in the Ward Accreditation on Oxborough ward where nursing levels were comprised of 53% agency nurses and he advised that substantive staff wanted the same agency staff each time. EH advised that although she would encourage continuity where possible the Trust is reliant on the agency staff.

	• Peter Tasker noted that the elective C-section rate had doubled in December and queried whether this was due to patients wanting to have their babies prior to Christmas - EH was unable to confirm this but she has asked O&G for a review. The number of C-sections may have been appropriate but she will confirm. • Barry Taylor referred to the emergency C-section rate which fluctuated – he queried whether the decision to operate was made by middle-grade staff who may feel this is an easier option for a complicated birth. NL advised that the issue was being monitored – the report did not include data on tears and instrumental deliveries and these tend to dip when C-section rates are high. A consultant always makes the decision whether to carry out a C-section. **The Board noted the Quality update**	
02/18	**2. OPERATIONAL PERFORMANCE**	
	The Board considered the report and discussion included: • SJ advised that there was an error at the bottom of the front page – it should read 80.9% not 86.9. • December was a difficult month with increases in both activity and acuity, combined with staffing challenges. • Ambulance turnaround times were challenging, particularly in the 0-15 minute category. Performance in the 0-30 minute category had improved slightly to 87%. • Initiatives have been put in place to improve performance – the SAFER initiative lasted almost 2 weeks and was aimed at admission avoidance. Gary Hardy, Commissioning Manager from the CCG was in attendance during the initiative and was highly successful in discharging patients back into the community. • Cancer performance was better than forecast despite a high degree of patient choice. Performance remains very fragile, with a possibility of a dip in January. There is a daily focus by the Operational team to get patients through the pathway in a timely way. • RTT performance of 81.3% reflects the operational challenges – some elective capacity was used for emergencies. Surgery has maintained activity where possible by maximising day cases. • IP queried what more can be done to improve patient flow – SJ advised that early discharge could be improved; both Surgery and Medicine are failing to achieve the target of pre-midday discharges. There is also more work to be done with community partners. • IP noted that there had not been any improvement in theatre lists starting on time– SJ explained that frequent movement of the Admissions Unit has been an issue; as Leverington will now be operational for the next 3 months a fixed Admissions Unit will need to be found. Once this is implemented an improvement in theatre starting times should be evident. • DT queried whether additional resources provided during the SAFER initiative could be continued – SJ advised that some would be; although the use of ward liaison officers is not possible, the team are trialling the use of 'buddies'. Point-prevalence will continue each day – this provides data on what each patient is waiting for and allows for easier	

	escalation. NL advised that a pilot service had also been put in place, allowing GPs to speak directly to a consultant; this allows patients who need to be seen quickly but not admitted, to attend a 'hot clinic'. • EL referred to the sub-optimal RTT performance and queried whether there was any risk of patient harm as a result – SJ advised that divisions were working in collaboration with consultants; no patients regarded as 'urgent' or any cancer patients were postponed unless absolutely necessary. Those patients who had been on the waiting list for a long time were being reviewed to ensure their condition had not deteriorated. No patients have waited in excess of 52 weeks. • NL confirmed that both Respiratory and Cardiology consultants were reviewing the notes of all patients waiting longer than 12 weeks. He felt that it was not possible to eliminate all risk but that the Trust was doing everything possible in mitigation. • Betty Lewis queried the use of point-prevalence on the wards – SJ advised that this was used to identify Red2Green patients. • Betty also queried Gary Hardy's role during SAFER week - SJ advised that he had been solely focussed on moving patients to the most appropriate place of care. • EC queried whether the NEDs could provide assurance that the extension to A&E was being utilised effectively. IP advised that the Primary Streaming Unit was not being utilised as originally intended due to challenges with staffing it; however, the Trust is making the best use of the resource. JG explained that the area was transformed with DoH monies for Primary Care streaming; recent performance has resulted in an increase in patients with higher acuity who would not have needed to be seen by a GP. Use of the unit will be reviewed later in the year. • **DT requested that a report be submitted to Finance & Performance for assurance. JG advised that this will be included as part of CM's operational report.** • Simon Clarke queried why there were delays to theatre list start times - SJ explained that consultants see patients on the Admissions Unit prior to the operation but the unit has been moved, following the use of Leverington as an escalation area. On the Admissions Unit processes are well established - when the unit is moved, these processes take longer, as staff are unfamiliar with the layout. • EC asked the NEDs if they were assured that the delays in theatre and movement of the admissions unit were not impacting on patients. SJ replied that all patients are asked to ring the hospital at 6.30am on the day of their operation to ensure a bed is available and they are then advised where the Admissions Unit is situated. Surgeons have also staggered their lists, so some patients are being admitted later in the morning, meaning less space is required on the Admissions Unit and there is a shorter waiting time for the patient. • Steve Clark referred to the use of community beds and queried how the Trust can build on the success achieved by Gary Hardy. JG advised that Gary had been very tenacious; the biggest difference was the range of monies available due to the time of year, resulting in more beds in the community in early January. Crisis management can be effective in the short term but is not sustainable in the longer term. • JG advised that all hospitals had been advised to stop elective work during January to concentrate on emergencies. The Board took the decision to not stop due to the potential impact on both patients and	**CM**

	financial recovery - all patients were telephoned prior to their operation and warned of the possibility of cancellation; they were also given the opportunity to rebook in April. A press release was issued to local media, advising patients to attend for their appointment unless they were contacted directly. **<u>The Board noted the Operational Performance update</u>**	
03/18	**3. FINANCE**	
	The Board considered the report and discussion included: • The Trust had a forecast deficit of £16.3m in March, this is now £18.7m; RJ advised that there was an element of risk of delivery and the regulator has been fully informed. The Board is meeting regularly to discuss the issue, particularly as the pressure increases through January-March. • RJ was clear that the Trust needed a clear plan for 2018/19 as the Board did not want to be tied in to a control total without being fully informed. The Trust must be realistic and transparent with the regulator. • EL advised that the Trust had been under the threat of financial special measures but the regulator recognised that the Board has been consistent in its forecasting. • EL queried the status of the business case relating to the roof - RJ advised that the case needed to go through one more stage of scrutiny at DoH – he was hoping for a swift response. • EL noted the £18.7m revised forecast deficit and queried whether RJ felt this would be achieved - RJ acknowledged that it would be a challenge. • IH queried the status of commissioning claims raised by WN CCG – JW advised that the Trust and WN CCG had been involved in arbitration, which found in the Trust's favour, securing £2.5m. There continues to be a high level of challenge to income with the number of claims increasing. • IP queried how much resource was required to respond to these claims – JW that the Trust has a validation resource to avoid claims coming in and the Trust has to respond within 10 days – this involves 2 staff with senior support. • Peter Tasker had been concerned to read a letter to the BMJ from WN CCG, claiming they had been ordered to stop locally enhanced service payments. Peter felt that this will have an impact on acute trusts. JW was unable to comment on the letter but acknowledged that it is a concern and he was in discussion with the CCG. • EC sought assurance from the NEDs that budgeting for 2018/19 will be accurate. DT advised that he was assured that the Trust will agree 2018/19 budgets, which are achievable. RJ advised that he will bring a realistic and deliverable figure to Board. EC confirmed that there is Governor support for the Board to deliver a realistic and achievable plan to the regulator. **<u>The Board noted the Financial update</u>**	
04/18	**4. WORKFORCE**	

	The Board considered the report and discussion included: • KC advised that the composition of the hospital staff had improved with a decrease in agency staff and an increase in bank usage. • There has been a rise in sickness levels after two months of improvement following termination of the FirstCare contract. Managers have demonstrated a level of flexibility when staff call in sick, which has resulted in the numbers decreasing. • The Trust has seen a significant improvement in recruitment processes, achieved by working differently; KC advised that the Trust's 'time to hire' is now within 'gold' standard. • The HR team will now address mandatory training processes using PDSA (Plan Do See Assess). • EL and KC had taken part in a meeting with UEA to discuss nurse advocates – UEA has seen a significant shortfall in the January intake of nurses; KC advised that January is traditionally a more challenged intake; however, the conversion of bursary to student loan has also impacted intake. • Referring to overseas recruitment, KC advised that working visas are allocated by quota and only if an organisation can demonstrate a shortage of a particular role can they fill outside the quota. The Trust has had one role declined twice and is currently relying on agency staff. This was raised with the Secretary of State who visited the Trust in January and letters of information have been sent to his office directly. This issue also affects an individual's 'right to remain'. • IP referred to the reduction in training and appraisal rates and noted that the comments in the 'actions' section do not address the issue. KC advised that moving forward, training will not take place in January as operational pressures often mean the sessions have to be cancelled. Frequency of training requirements is being reviewed. The Trust remains committed to working towards 95% compliance. • 'My ESR' is an app being used for mandatory training (including e-learning), which will be rolled-out Trust-wide. • EL noted that staffing is a significant challenge for the Trust and queried whether the staffing strategy had been finalised - KC advised that the overall Workforce Strategy has been approved and is currently being implemented. • A Recruitment and Retention subcommittee has been established as a task and finish group to implement the Recruitment and Retention Strategy, which will be submitted to the Workforce Committee in June. • A Leadership and OD committee has also been set-up to implement the Leadership and Cultural Change Strategy which will be submitted to the Workforce Committee in April. • IH noted the significant improvement in pre-employment checks – KC advised that this was due to reminders sent via email. • DT noted that the majority of the report is rated 'red' and queried whether targets could be stepped down temporarily - KC advised that targets are being reviewed to ensure they are realistic realistic. The Workforce Strategy does have progression targets for all areas – these will be separated for individual staff groups. DT suggested that sickness levels be divided into short-term and long-term absences. • Robin Brooke queried whether the Trust is able to assist staff who are on sick leave with access to an early GP appointment - KC advised that	

	the Trust does not have that ability, although it does expedite hospital service in line with policy. NL agreed, adding that the Trust cannot influence primary care however he will raise the issue during his monthly meetings with GPs. • Betty Lewis referred to mandatory training and queried whether staff received reminders for mandatory training or whether they needed to access 'My ESR' – KC advised that if staff are registered on 'My ESR' then they will receive prompts. • Simon Clarke queried who was fulfilling the FTSUG role - EL advised that recruitment was ongoing but he will ask one of the NEDs to fulfil the role temporarily. • Steve Clark noted that the staff turnover rate was high and queried whether the Trust was doing all it can to look after existing staff. KC acknowledged that there would always be more which could be done; however, simple measures such as coffee and cake has been well-received and staff appreciation was a priority. **The Board noted the update**	
GOVERNORS' QUESTIONS		
05/18	• Simon Clarke asked KC for an update on allegations of bullying at the Trust. KC advised that she had seen comments on the staff FFT, which seemed to indicate a bullying culture so she had commissioned an independent anonymous survey which received 36 fewer allegations than the previous staff FFT. There were 350 responses to the survey, 46 of which have proved useful; many responses failed to provide examples of bullying experienced or witnessed. • HR is working with five specific areas where sufficient information was received to identify an issue – KC advised that the aim was to work with the department on acceptable behaviours rather than to apportion blame. This work ties in with recent Behaviours Workshops. • JG noted that the Board had discussed strategy / vision and these have to be underpinned by refreshed values and behaviours. • The bullying survey results will be presented to the Workforce Committee in February. • Simon queried whether the next staff FFT would be reviewed to determine whether there is any trend identified – KC confirmed it would. • JG wanted wider staff participation in the Behaviours Workshops - only 10% of the workforce have attended to date • Nigel Tarratt felt that some comments could be related to previous senior management and subsequent changes in management may take time to filter through. • Sheila Young (NCH&C) was pleased to hear the discussion as she believed staff morale was highly important and felt there had been an improvement over the last year. • Robin Brooke advised that the majority of visitors and staff using the main entrance are not washing their hands in the sinks provided. RJ advised that it was not possible to constrict the entrance to corral visitors to use the sinks. EL commented that during the Secretary of State's recent visit, he noted that this was the first visit in 51 trusts	

	where he had been asked to wash his hands. • Nigel Tarratt noted that funding for staff training was withdrawn last year and had to be provided from individual department budgets, which meant that many staff were unable to take up training opportunities. **This was likely to impede recruitment and retention and he asked the Board to review this for 2018/19 - EL agreed.**	**Board**
QUALITY		
06/18	**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. CM was unable to attend as she was at a meeting regarding Ambulance Trust issues – EL welcomed S Jones to the meeting as her deputy. Apologies were received from M Ashton and C Moore.	
07/18	**6. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 28th NOVEMBER / MATTERS ARISING**	
	The minutes of the meeting held on 28th November were considered to be an accurate record of the meeting.	
08/18	**7. ACTIONS MONITORING**	
	The Board reviewed and updated the Actions Monitoring Record. Actions 21, 26, 30, 33 and 37 were considered complete and were removed from the action log. **See Action Log for further updates.**	
09/18	**10. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA**	
	None	
10/18	**11. URGENT ACTIONS (UNDER STANDING ORDERS PARA 5.2)**	
	a. Short Term Loan • The Board noted that this had been signed-off last week. **The Board approved the Urgent Action in relation to the Short Term Loan.**	
	b. IT Switches • RJ advised that there had been a change in the choice of IT switch during the processing of the business case, which led to a substantial	

	price increase; he had since obtained a time-limited improved quote, which had been approved by Urgent Action outside the meeting. **The Board approved the Urgent Action in relation to the IT Switches**	
11/18	**12. CEO'S UPDATE**	
	• JG re-emphasised his gratitude for how staff have been working over recent weeks. He has attempted to visit all wards to see how staff are and to hand out vouchers for coffee/cake. Staff in some non-front-line areas handed back their vouchers and asked him to pass them on to front-line staff – JG felt this was a demonstration of staff supporting each other. • The visit by the Secretary of State was part of a tour and staff filled the lecture theatre to hear what he had to say about safe care across the NHS. • With regard to the forthcoming CQC visit, JG confirmed that the Trust has not yet received the official request for information – the PIR – however work is continuing on QM. • The STP will be discussed in more detail later in the meeting but JG advised that there is movement across the 3 hospitals to review how each can align themselves and work locally. • JG received a letter from Celia Ingham Clarke – Medical Director at NHS England – congratulating the Trust on being one of the most improved organisations in the UK in relation to Sepsis. Paediatrics also received an award for training. **The Board noted the CEO's update**	
12/18	**13. CHAIR'S REPORT**	
	• ED acknowledged the significant pressures the Trust is facing with regard to demand and acuity. • There are financial issues, which need to be resolved and work is ongoing to address this. • The day prior to the Secretary of State's visit the Trust achieved 96% A&E performance. • During the Volunteers' Christmas lunch, EL agreed to spend a morning on the front desk – he was surprised at how busy the desk was and he was minded of how dependent the Trust is on its volunteers. **The Board noted the Chair's Report**	
13/18	**14. PATIENT STORY**	
	Claire Roberts introduced Samantha Boyle who advised that her son Daniel had been born deaf and that she wanted to explain his journey. Also in attendance was Simon Hill, Chief Audiologist. • Samantha acknowledged that the Audiology department does not save lives but the service they provide was life changing for Daniel and ensured he was not isolated. • She explained some of the challenges Daniel faced as a young child – lip-reading, not being able to hear safety alarms, having to read	

	subtitles, unable to hear cars when crossing the road. • Daniel is Samantha's second child. The day he was born he failed his new-born hearing test but the audiologist suggested it might be due to mucus so returned to try again the following day - Daniel failed the test again. He had an auditory brain test the day after discharge from hospital and results showed that Daniel had been born moderately deaf with a high frequency hearing loss. • Daniel had his first hearing aids fitted at 8 weeks. He was later identified as having progressive hearing loss and had a number of different hearing aids, each with more amplification. • Daniel has sufficient residual hearing to hear the letter 'D' and was proficient at lip-reading aged 2. • In March 2017 Samantha asked Simon to refer Daniel to the Cochlear Implant Centre. • The Audiology team provided an excellent service for Samantha and Daniel, helping to make appointments at the end of the day and getting to know Daniel (and his reactions) to make Daniel's hospital experience better. • Simon himself provided support to the family, seeing Daniel weekly at times and always fitting him in where possible, even in his lunch break. • Addenbrookes had issued Daniel with a set of new hearing aids but these malfunctioned, just as the family were about to go on holiday – Samantha rang Simon who ensured Daniel did not have glue ear and provided a new set of aids within 12 hours, saving the family a trip to Cambridge. • Daniel had multiple tests at Addenbrookes, followed by surgery for implants and managed to save Daniel's residual hearing. • In January Daniel's new implants were switched on and he is now hearing 45 decibels across both ears. There is still a long way to go but Daniel is making huge progress. • Samantha was extremely grateful for the early identification – this meant Daniel could access sound before speech and as such he does not sound deaf when he talks. • EL thanked Samantha and Simon for attending – he was delighted that the screening had proved so beneficial at such an early age. • NL also thanked Samantha, adding that he was very humbled by her story. He had not been aware of Simon and his service before today and was grateful she had brought the issue to his attention. • JW advised that services such as Audiology are out of the spotlight, and suggested Samantha tell her story to the CCG so they are aware of how vital the service is. He noted that many local trusts have moved these services outside the hospital and the ability to recruit / train staff depends on having the service within the Trust. • EH thanked Samantha and explored whether the Trust was ensuring that all patients who are hard of hearing have a full service - she will meet Simon to discuss. • Samantha pointed out that the Trust uses a telephone reminder service but Daniel could not hear the phone – Addenbrookes uses a text service which is easier for deaf people. • JG also passed on his thanks to Samantha and Simon; there are lessons for the executives in relation to hidden services. He also felt more thought should be given to those with hidden disabilities. The screening service is holistic care and one aim of the STP is to wrap services around	

	the patient which will make a significant difference to the local population 5-10 years from now. • EH advised that new-born hearing tests are part of a national screening programme and the Trust should ensure failsafe measures are in place for all patients, i.e home births. • **JG will meet with Nigel Tarratt to ensure the executives have sight of all therapy services.** **The Board noted the Patient's Story**	**JG**
14/18	**15. REVISITING THE PATIENT STORY**	
	The Board considered the report and discussion included: • EH advised that a lot of work has been on-going following the patient story on delirium, with increased awareness for medical staff and joint-working with the CCG to improve services. • The Trust is looking at an interim service to support patients going home with delirium, including support for the family. • The Mental Health Liaison Service is now fully staffed. **The Board noted the Patient Story update**	
15/18	**16. QUALITY ASSURANCE AND CQC COMPLIANCE**	
	The Board considered the report and discussion included: • EH advised that Lou Notley, Associate Chief Nurse – CQC Implementation Lead - had settled in well and is currently arranging mock visits; EH thanked those who had volunteered to take part. Lou met with NEDs today to discuss the methodology of the mock inspections. • Several issues have been identified, i.e use of Leverington Escalation ward. The recording of staff training in the use of equipment is being addressed; resus training has been a challenge; however, the team is being strengthened to ensure the training process is as robust as possible. • Lots of work has been carried out in preparation for the PIR – once it arrives the Trust will have 3 weeks to provide 3-400 pieces of information. JW's team is working to ensure data is ready and accurate. **The Board noted the Quality Assurance / CQC Compliance planning update**	
RISK		
16/18	**17. BOARD ASSURANCE FRAMEWORK**	
	The Board considered the report and discussion included: • JG advised that some aspects of the BAF had been updated for clarity, particularly in terms of finance. • EL noted that Risk 2 (failure to deliver short or longer term financial plans) was rated as 'certain' but that the Trust is delivering its financial	

	plans, so queried whether it related to the Trust's relationship with the regulator. JG advised that the risk reflects staffing challenges, increased demand and CCG funding. Relationships are covered in Risk 3. **The Board endorsed the Board Assurance Framework (BAF)**	
17/18	**18. CORPORATE RISK REGISTER (>15)**	
	The Board considered the corporate risk register and discussion included: • GR and Lou Notley joined the EDs' meeting last week and examined the process for reviewing all 15+ risks and all individual risks. The EDs were challenged to work in pairs and review their risks. Consideration was given to articulation of each risk – the aim was to be consistent in terms of risk articulation and rating, without diminishing the risk. • The new Head of Risk and Governance is starting at the Trust at the end of March. EH is hoping that they will assist with the articulation of risks. • The Risk Committee is aiming to ensure sufficient understanding of high risks, particularly those which have been on the register for a long time. • IP was pleased to hear this as he noted that some risks had remained unchanged on the register for over 2 years - he questioned whether these risks should be rescored or whether the mitigation was accurate. **The Board noted the Corporate Risk Register update.**	
REGULATORY AND GOVERNANCE		
18/18	**19. PERIODIC REPORTS**	
	The Board considered the reports: **a. Guardian of Safe Working** • NL explained that the role of the Guardian of Safe Working (Chris Lloyd) was designed to provide independent scrutiny of the junior doctors' new contract to ensure they are not exceeding contracted hours. • The role also ensures junior doctors receive appropriate breaks / training opportunities. • Chris felt that the lack of reporting reflects a degree of complacency on behalf of the doctors; he continues to encourage the junior doctors to report breaches of the contract. • The report notes that Chris has requested more information on bank / agency staff – NL advised that this is being provided. • EL queried whether the junior doctors were satisfied with the new contract - NL advised that the Trust has done everything within its gift to mitigate the introduction of the new contract and has been fortunate to be able to fill all rotas; however, the majority of doctors appear to be less happy than under the previous contract. EL queried whether there was anything the Trust could do - NL advised that the Trust is providing a good educational experience, although there is	

	room for improvement. Both the Trust and the junior doctors are frustrated by the detail in the contract and would prefer more flexibility. • IH queried whether registrars / supervisors were available for the doctors to raise concerns – NL felt that they were but that there would always be cases where clinical supervision was not as good as was hoped. He added that short overruns of clinics are acceptable but regular, or long over runs should be identified. A cultural change is required for both juniors and consultants and this will be a challenge. **The Board noted the Guardian of Safe Working update**	
19/18	**20. POLICIES – NONE**	
20/18	**21. BOARD OF DIRECTORS – FORWARD PLAN**	
	The Board noted the Forward Plan	

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 – 27th March at 10.30am in the Inspire Centre.

There being no further business, the meeting was closed at 3pm