The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

Minutes of the meeting held on 28 November 2017 at 12pm 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
M Ashton (MA)	NED
I Harvey (IH)	NED
E Hardwick (EH)	Chief Nurse
N Lyons (NL) from 12.30pm	Medical Director
R Jackson (RJ)	Director of Finance
J Wade (JW)	Director of Strategy & IT
K Charman (KC)	Director of HR
In attendance:	
A Adams (AA) item 19a	Freedom to Speak Up Guardian
H Barnes (HB) item 15b	Midwife
C Weatherill (CW) item 15b	Midwife
E Corner (EC)	Lead Governor
D Chessum (DC)	Head of Communications & Engagement
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer - minutes

		ACTION
107/17	**1. CEO'S UPDATE**	
	The Board considered the report and discussion included: • This update was given as a Staff Briefing last month after JG's first 6 months in post. Some challenges remain – quality, workforce and finance. • The Trust is currently focussing on winter pressures – this is a challenge faced by the entire NHS. • Additional funds were allocated to the NHS as part of the recent budget – JG will be speaking to the regulator this week to ascertain how monies will be spent to support delivery of emergency / urgent care to year end. • The Trust has jointly developed a free app "Choose Well" which is based on the user's location, advises on length of wait at the nearest A&E and suggests alternative treatment options such as a drop-in centre or minor injuries unit. • EL referred to the recent national budget and noted that £350m will be held centrally and allocated to A&E schemes across the country. Some funding will be allocated to STPs - the local bid will be refreshed. • IH queried how attuned the organisation is in relation to savings / good housekeeping – JG advised that the EDs take on board a range of views, sources include the 'Team QEH' email and work CM is undertaking with	

	budget holders ('back to black'). He felt that as the Trust had been in deficit for several years it had become culturally accepted by the organisation. • MA referred to the app and queried whether there would be any evaluation on success / lessons learnt - **JG will bring feedback to the next Public Board meeting.** **<u>The Board noted the CEO's update</u>**	**JG**
108/17	**2. CHAIR'S REPORT**	
	The Board considered the report and discussion included: • EL acknowledged the challenges both operationally and financially and congratulated the Board for maintaining operational performance. • There had been a visit from the Chairs of the CQC / NHSi – this had been a real opportunity to showcase areas of excellence and the Chairs left with a good impression of the Trust. • The Trust is continuing to develop relationships with both UEA and CoWA – this is important to the Trust in terms of securing a recruitment pipeline for the future. • The High Sheriff of Norfolk visited the Trust, having a special interest in supporting volunteers and was impressed with the areas he visited. **<u>The Board noted the Chair's Report</u>**	
INTEGRATED PERFORMANCE REPORT		
109/17	**3. QUALITY**	
	The Board considered the report and discussion included: • The outbreak of C.Difficile lasted 4-6 weeks and was declared following increased incidents on Stanhoe and Windsor wards. Actions were put in place relating to cleaning standards, handwashing and antimicrobial stewardship. • Deep cleaning has taken place, using Leverington as the decant ward. • Deborah Adams [Infection Control lead at NHSi] visited in October and was very helpful, sharing ideas and providing assurance. She has continued to support the Trust. • IH noted that it had been a month since the last case and queried whether the outbreak had been closed - EH advised that in conjunction with PHE / CCG/ NHSi it had been decided not to call off the outbreak as some community-acquired C.Difficile cases had been reported along with a case in an area which had previous C.Difficile cases. She hoped to call off the outbreak this week. • MA queried whether there had been any systemic changes - EH advised that a wrap-up session with external partners was taking place on 1st December. Some areas need to review IPAC activity and determine what could be done differently. • IH queried whether EH had any plans to address MSA breaches – she has discussed the issue with the CCG and noted that the breaches relate to the onward movement of pts from ITU.	

	• EL queried how quickly the Trust responds to complaints – EH acknowledged that response is not always as timely as it could be; C Roberts is reviewing the process to determine how the Trust can ensure staff are having a conversation with the complainant and produce a timely response to questions. KC and the HR team are working on behaviours across the Trust which should help to improve attitude / communication issues. The Trust could carry out observations of care / positive interactions and provide feedback to improve communications. Nurse staffing update • EL suggested reviewing the report outside the meeting and considering the implications particularly in relation to Model Hospital recommendations. • EH signposted to item 3a on page 8 which looks at staffing exceptions. She felt it was important to understand the impact of short-staffing, i.e. red-flag events. • EL felt the report should be considered alongside KC's report for triangulation purposes. **KC will pick up with EH and bring a triangulated report in January**. KC suggested the need for realistic trajectories in each area. • IH asked for clarification on the role of CDU – EH explained that CDU is located in ED as part of the observation bay; patients are seated and can be seen and either discharged or transferred quickly. They may need to wait for diagnostic tests and have a plan of care to avoid admission. **The Board noted the Quality update**	**EH / KC**
110/17	**4. OPERATIONAL PERFORMANCE**	
	The Board considered the report and discussion included: • RTT performance is below target; recovery plans are in place. The trajectory indicates recovery should take place by the end of the financial year, although the Trust is aiming for the end of December 2017. • The Trust is under-delivering on income as it is not seeing the predicted level of activity. • A&E – despite 2 months of good performance the second-half of November has been challenging with figures dropping to 82-85%. The dip in performance is linked to the recent IPAC issues and the acuity of patients – there has been a significant rise in 'majors' being admitted, with an increased length of stay. • Winter plan – focus is on flow / emergency care. • 62-day Cancer – the Trust continued to deliver throughout October. • EL queried how primary care streaming was progressing. NL advised that there are no GPs available to provide the service. The Trust is working with the CCG / NHSE to ensure compliance with regulations relating to funding for the service. The service is likely to be predominantly nurse-led and will operate at times of peak attendance which should ease pressure on the ED. Other measures to assist flow include use of ambulatory care and ensuring GP referrals go directly to	

	MAU / ward area. • IH queried whether the Observation Bay had been closed - NL advised that in order to release doctor capacity for the front door, the team had considered closing the Observation Bay but recognised this was not always practicable so the bay remains open. • MA referred to Cancer 62-day and noted that despite a good start the performance has moved to 'fragile' – she asked how this would move to 'robust'. JG explained that to a degree cancer performance will always be fragile, but the aim is to treat patients as quickly as possible. The risks to performance included a change in the cancer management team with the interim arrangement not as robust as expected. MA queried whether there was operational support for the service – JG acknowledged that there was some support but optimum support will not be in place until the new operational structure is implemented. • IP referred to the external review of the ED and asked how quickly the Trust will move from analysis to putting changes in place as a result. JG advised that the ED staff have been working alongside the ECIP team since July and improvements have been made continuously. IP then challenged why performance was decreasing – JG felt it was multi-factorial and it was possible to correlate ED performance with the opening / closing of wards in relation to IPAC issues. He acknowledged that there were not enough days in the month to recover performance in November. • EL asked the executives to come back to Board in January with a follow-up report on the actions taken following the ED review. He was keen to know how the Trust compared with other DGHs. NL explained that the ECIP report details best practice and how to achieve it. **CM / NL will bring the report in January.** **<u>The board noted the Operational Performance update</u>**	**CM / NL**
111/17	**5. FINANCE**	
	The Board considered the report and discussion included: • The Trust has made a loss of £1.8m in October 2017, and £13.2m year to date. This is £0.6m adverse to plan in October and £3.2m adverse to plan year to date. • The year to date adverse variance is driven by a £2.8m shortfall against budget for clinical income of which planned care accounts for £2.5m. • Plans are in progress to recover financial performance and deliver a deficit as close to £16.3m as possible. • Conversations with the regulator regarding variance from plan are on-going. • CIPs are £1.9m behind plan • Capital – the revised plan is for £6.1m; to date the Trust has spent £1.9m; a capital loan of £700k has been applied for. • The Strategic Outline Case (SOC) for roof repairs costing £22m over 5-6 years has been approved locally and is awaiting national approval. if approved work will start early next year. • EL advised that he, JG and RJ have a meeting with the regulator on Friday where they will conclude a deliverable forecast deficit. He confirmed with RJ that the Trust had reviewed and complied with all	

	cost-saving items on the list from NHSi. RJ added that the Trust had used the same 3 sets of savings tools which would be applied by an external financial team. • IP noted that during the Finance & Performance Committee there was an in-depth discussion on cash-flow and the Trust's potential vulnerability in that area. He asked RJ to outline the discussion for assurance. RJ explained that cash projections had been sent to NHSi based on the current run rate and that the Trust had re-scheduled local arrangements with the commissioner. The Trust will be drawing down cash later than originally planned. • IP was concerned by the Trust's failure to deliver the CIP target and queried what could be done differently next year to ensure delivery. JG felt that failure to deliver was, in part, due to not starting work on CIPs early enough. Another contributory factor was a lack of realism – not all plans survive, some are high risk and have no mitigation. It was hoped that as a consequence of the meeting on Friday there may be some support for this year. The Trust needs a longer term plan to achieve true transformation and should review the cost base over years 1, 2 and 3 – there needs to be a fundamental review to avoid being in a 1 year cycle. Although the Trust may need help to set this up it must be QEH staff who drive the work. • MA noted that RJ has to present the paper which explains what happens and queried the appetite within team to deliver - JG explained that any one of the EDs could have gone through the papers as the whole team are aware of where numbers are leading. He was aware that further down the organisation understanding was not as comprehensive. This issue was discussed at TEC last week and JG had conversation with surgeons. The financial message needs repeating throughout the organisation. **The Board noted the Financial Update**	
112/17	**6. WORKFORCE**	
	The Board considered the report and discussion included: • The number of staff in post is rising again after several months of decline. • The 'Top 10' areas of concern include 7 within Medicine and 3 within Surgery. HRBPs are working to support those areas. • 72% of front line staff have had their flu vaccination; there has been cooperation across staff groups. • The focus on appraisals is beginning to show results. • Mandatory training remains a concern. Several areas are responsible for delivery – KC acknowledged that communications regarding training could be improved. A multi-disciplinary steering group should help, working on a rolling plan for the year. • October was the first month without FirstCare and the Trust has seen an increase in sickness absence. Anecdotal feedback is that managers have preferred to manage absence individually. HRBPs are addressing the sickness absences. • The Trust is no longer using agency HCAs following recent recruitment. • **KC/ NL are working on a medical staffing tracker – to be updated in**	**KC/NL**

	March. • IH was pleased with the positive data on flu vaccinations and appraisals. He noted that agency HCAs are no longer required and that nursing agency hours are falling but agency spend is continuing to rise. KC advised that the report details hours rather than overall spend. Hourly rates are also reducing. RJ noted that the Trust is an outlier for agency usage. **KC will share more data at Workforce Committee.** • KC felt it was important to know how slow the recruitment process can be – prior to the implementation of TRAC the Trust moved from a significant backlog to one of largest inductions seen all year after its implementation. The graph illustrates the 'perfect' process and compares this to QEH – performance is improving. • KR advised that HR is not simply about recruitment – the team are currently reviewing behaviours at the Trust. • There will be a monthly newsletter from HR on how to manage staff well. **The Board noted the Workforce update**	**KC**
GOVERNORS' QUESTIONS		
113/17	• R Brooke – raised a concern about the appointment booking system as he had been sent several dates which were not convenient. JG advised that the Trust used a traditional booking system and with large volumes of patients it was not possible to be completely flexible. A review of the service would include how to work with GPs regarding referrals and how to make the service make more efficient without making it more expensive to run. Referrals are received both electronically and on paper. JW added that the Trust is not losing income with cancelled appointments as all clinic slots are full. • P Tasker – referred to the ECIP review of A&E and noted that 26% of patients did not need to visit A&E. He queried whether there are any clinical themes / groups of patients within this percentage; if so, this could be fed back to primary care. NL explained that work was on-going; although there was no clear theme identified there were common geographical areas noted and the Trust is working with GPs via the CCG. Patients are also coming to A&E from care homes and often their need was not best served by A&E. B Lewis queried whether NL was working with Wisbech / Lincolnshire GPs - NL did not have relevant data but was meeting consultants and GPs this evening. • S Clarke had trialled the new 'Choose Well' app and found that there were no viable local alternatives to attending A&E. There is a minor injuries unit at Wisbech but if the patient cannot travel they need to contact their GP who would require proof of identification prior to sending an appointment. • R Brooke queried whether the Trust took care of its junior doctors. NL advised that the Trust is working with Health Education East to make improvements in this area. A recent survey shows an improvement in doctor satisfaction from the previous year, with each training area	

	requiring improvement having a clear action plan. Junior doctors can make an 'exception report' via an app; they also have a Guardian of Safe Working who holds the Trust Executives to account. • A Walder queried what sustainability looked like - JG advised that the Trust needed to look at other models and this is likely to be early next year. • S Clark considered patient safety to be paramount, regardless of spend and was delighted to see good performance highlighted despite the financial position. He noted that other trusts are in same position financially and considered it highly unlikely that the regulator would place all trusts in special measures. JG agreed, citing finance, quality/safety and performance as crucial to the Trust. • N Tarratt referred to mandatory training and noted that one of the lowest performing areas was infection control. He asked NEDs if they were satisfied adequate actions were in place. IP advised that this issue had been raised at Workforce Committee in October and he had received assurance on plans being developed although there was still some way to go. N Tarratt was pleased to note that compliance with hand hygiene training had increased from mid-80% to mid-90%.	
QUALITY		
114/17	**7. CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE**	
	EL welcomed the Board to the second part of the meeting. Apologies were received from D Thomason, M Carson and C Moore.	
115/17	**8. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 26th SEPTEMBER / MATTERS ARISING**	
	The minutes of the meeting held on 26th September were considered to be an accurate record of the meeting.	
116/17	**9. ACTIONS MONITORING**	
	The Board reviewed and updated the Actions Monitoring Record. Actions 9, 12, 13, 15, 16, 18, 19, 20, 22, 23, 24 and 27 were considered complete and were removed from the action log. **See Action Log for further updates.**	
117/17	**10. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA**	
	None	

118/17	**11. URGENT ACTIONS (UNDER STANDING ORDERS PARA 5.2) – CAPITAL PROGRAMME STRATEGIC OUTLINE CASE (SOC)**	
	• The Strategic Outline Case (SOC) has been submitted and approved regionally but is awaiting data for national approval.	
119/17	**12. PATIENT STORY**	
	Patient was unable to attend.	
120/17	**13. REVISITING THE PATIENT STORY**	
	The Board considered the report and discussion included: • In July the Board heard from a gentleman who had suffered with delirium and EH updated on the on-going work within the organisation since then. • Written information on delirium and mental capacity has been circulated to consultants / teams involved in delivering patient care. • At September's meeting the Board heard from a patient who compared treatment at both NHS and private organisations and raised concerns about pain relief offered by QEH. NL has discussed with medical colleagues and found that delayed pain relief had been a result of prioritisation – this will be addressed. • The same patient was critical of administration processes at QEH – JW met with him yesterday and they are working through issues. **To be updated at January Public Board meeting.** **<u>The Board noted the Patient Story update</u>**	**JW**
121/17	**14. QUALITY ASSURANCE AND CQC COMPLIANCE**	
	The Board considered the report and discussion included: • The report updated on progress in preparation for the forthcoming CQC inspection. • Themes are coming through from staff to ensure they understand 'who's who' – there have been several structural changes over last 8 months. • There has been some triangulation to ensure lessons learnt from SIs are circulated. • Teams are gathering information for the PIR – this will be sense-checked to ensure it answers the questions. • EL referred to the data on SIs on page 4 and felt that having action plans which are not being followed up is counter-productive. NL explained that the data related to process rather than lack of action. He is confident that the latest SIs will be followed through and updates completed on SIs from last year. The Risk & Governance team are working through the SIs and when they find missing actions they can identify where the process failed to ensure it does not happen again. IP felt this was important as the Board may have received false assurance	

	previously. • EL advised that several members of the Board would be attending the NHSi conference on 'Moving to Good' next week – this would provide an important opportunity to reflect on the current position. • JG explained that the Trust had been invited by NHSi to take part in a programme 'Leading for Improvement' – likely to be in the new year. All trust boards will have to participate at some point but there will be a cost involved. By participating in the pilot study the Trust will receive both programmes – 'Organisational Approaches' and 'Measurement for Improvement' – free of charge. These sessions will be used as part of Board Development. **<u>The Board noted the Quality Assurance / CQC Compliance planning update</u>**	
122/17	**15a. NURSING & MIDWIFERY UPDATE**	
	The Board considered the report and discussion included: • The Trust has approved 1.4wte registered sick children's nurse to work in the ED to ensure compliance with 24hr cover. • Work to review the Model Hospital data needs to occur before final consideration of any recommendations can occur and that this should take place in the next 3 months. • MA referred to the IPR and queried whether the paediatric nurse in the ED would be sufficient to turn the data on page 21 'green' - EH explained that data on page 21 relates to medical staffing cover not ED. The Trust is slightly over-established on Rudham ward as a group of nurses qualified over the summer. • IP referred to the £58k financial impact of the 1.4wte in the ED and queried whether there were plans to recover the money elsewhere. JG explained that this sum is included in the run rate as the Trust has already been staffing at this level but this is now substantive; it had to be included as a cost pressure. Paediatrics will have to identify where the cost will be recouped next year. • IP referred to Appendix 1 and felt that the column which would contain national guidance could be used to include Model Hospital recommendations – EH will consider. • EL felt the Board should consider Model Hospital recommendations, current staffing levels and peer staffing levels – he suggested EH / RJ work on a matrix and bring back for discussion. • RJ queried whether there was a difference between the number of nurses on a ward or whether the element of nurse experience was weighted. EH advised that the senior nursing team used their professional judgement in terms of nursing numbers / experience but there were recommended ratios. • IH queried whether the Trust was expecting to receive any help from the Model Hospital - JG advised that the Trust is awaiting a date from NHSi once the data has been refreshed. EL felt the Board needed to understand the consequences of this, and would expect to see some detail by February / March 2018. IH agreed and queried what the Trust expected to gain from the Model Hospital - RJ advised that they have access to information not currently available to the Trust and he was hoping to be shown how to 'drill down'. • An acuity review will take place in January.	

	The Board noted the Nursing & Midwifery Update	
123/17	**15b. SUPERVISION OF MIDWIVES**	
	The Board considered the report and discussion included: • EH invited H Barnes (HB) and C Weatherill (CW) from maternity services to talk through the paper which outlined recommendations on how statutory supervision of midwives should be replaced at the Trust. • HB explained that there were 3 options to consider. The preferred option is A-EQUIP. • Option 1 refers to taking no action and is not a viable option as CQC include statutory supervision of midwives in their standard. • Option 2 suggests having a large pool of 12 Professional Midwifery Advocates (PMA) at a ratio of 1:20. The downside of this option is the time it would take to train 12 PMAs and this could lead to a disjointed service. • Option 3 recommends one full-time PMA with a small team available to support midwives on a 1:20 ratio. This is the preferred option from a leadership perspective but will require finance. The advantage is that one person can do their PMA training in 4 modules which is more timely. • The Trust needs to provide the PMA service and will be benchmarked. • CW explained that she had undertaken a 'conversion' course to become a PMA. She advocated for both patients and midwives. • Restorative clinical supervision will support midwives, helping them reflect and enhance their own practice. • The PMA role will include education / supervision and an element of quality improvement. It may also be a model which can be implemented across other professional groups at the Trust. • Any investigations will remain with managers. • MA queried whether the service could be disseminated - HB explained that it would need to be audited first but then could be applied to any allied professional group. Pilot sites only began training in January. • MA queried whether the midwives were talking to other trusts - CW confirmed she was and that Luton & Dunstable Hospital have just appointed 1 full time PMA. Other trusts are still deliberating. • IH asked KC about the provision of support for health care professionals at the Trust – she explained that this would be incorporated as part of organisational development. • KC supported option 3 as she felt this would generate stability and strength within the team. CW noted that if the Trust opts for option 3 then it will also need to create a supporting team. • KC suggested launching with option 3 then moving to option 2 once established. • EL noted the financial implications involved and assumed the EDs have agreed how this will be funded. He was in agreement with KC's suggestion. • IP queried whether the paper had been to TEC but it has not; EH advised that maternity services were asked to bring the proposal to Board in relation to the A-EQUIP model, ideally by September. **JG advised EH that she had complied with the request and the paper**	

	should now go to TEC to make funding / operational decisions. • RJ noted the framework in Appendix 2 which included drop-in support for revalidation sessions and he queried whether this is provided for all nurses - EH advised that this should be offered to all colleagues who do not have supervision. IH felt that this would open the financial floodgate for all healthcare professionals in the trust. • JG suggested amending the paper prior to presenting to TEC, taking on board KC's comments. **The Board noted the recommendations on statutory supervision of midwives and supported the adoption of Option 3 initially, moving to option 2 once established.**	**EH**
124/17	**16. WINTER PLAN PRESENTATION**	
	• The item was not presented as CM was absent. • EL sought assurance that there was a fully tested winter plan in place – JG advised that the plan was fully developed and was due to be tested last week as table-top exercise but this has been re-programmed for two weeks (w/c 11/12/17). **The Board noted the update on the Winter Plan**	
RISK		
125/17	**17. BOARD ASSURANCE FRAMEWORK**	
	The Board considered the report and discussion included: • GR explained that this was a summary report; the full BAF will be reported at the Private Board as it contains sensitive information. • There has been no movement in the residual risk and the same level of risk regarding quality remains. The CQC inspection will be a key source of assurance on quality. • Workforce remains a significant risk although GR expects this to improve sooner than the rest of the BAF. • Once the roof issues are resolved the infrastructure risk can be reduced. • EL considered the risk appetite for quality and acknowledged that there is sometimes a compromise between quality / safety. **He felt the Board needed to have an agreement on risk appetite and risk tolerance – to be picked up at Board development.** • MA felt that a CQC inspector may think the Trust carried a lot of residual risk and queried a timescale for improvement. GR advised that the BAF is designed to provide assurance for the Board; if the CQC rate the Trust better than 'amber' then this is extra assurance for the Board. She asked the Board to consider whether they required any additional source of assurance / commission extra work. **The Board endorsed the Board Assurance Framework (BAF)**	**GR**
126/17	**18. CORPORATE RISK REGISTER (>15)**	
	The Board considered the corporate risk register and discussion included:	

	• EH advised that the process of reviewing risks is ongoing. • One high risk has been downgraded along with a moderate risk relating to antimicrobial stewardship. • Divisional teams are very engaged; P Pratt has provided support and is making good progress. • **IP queried the difference between Risk 2373 and Risk 2399 – EH advised that they were the same risk, added by both Pharmacy and Corporate – to be amended.** **<u>The Board noted the Corporate Risk Register update.</u>**	**EH**
REGULATORY AND GOVERNANCE		
127/17	**19. PERIODIC REPORTS**	
	The Board considered the reports: **a. Freedom to Speak Up Guardian** • AA advised that she has been working at the Trust since the end of April. This is her first report. • It is a recommendation from the National Guardian's Office that each organisation should have a Speak-Up NED to work with the FTSUG. • IH noted AA's remark that "the challenge has been managers not taking action or inappropriately passing down" – AA explained that staff do not have to escalate to the highest level to get a response. She found it challenging to engage staff who were not executives and found she is often passed to more junior levels of staff. She is mindful of the significant operational pressures facing managers but feels that her role is not taken seriously enough. • EL explained that MC had been the interim FTSUG prior to AA's appointment. AA advised that national thinking had moved on, and whilst a Speak-Up NED is a recommendation it is not mandatory. • EL noted that 5 staff have raised concerns since the end of April while at other trusts the number was closer to 50 and queried why; AA was unable to answer but noted a difference in reporting nationally. • RJ queried whether AA felt that staff were aware of her role – her photograph had been added to a screen-saver and there were A0 posters around the Trust. AA acknowledged that people recognised her but did not make use of her service. • MA suggested the Board consider how best to communicate to staff that there is an opportunity for them to voice their concerns regarding safety. She felt that a cultural change needed to happen – if these processes do not work then staff will use others methods, i.e CQC. • JG acknowledged that there are pockets of staff in the Trust which have issues; KC is reviewing grievances. The Executives are working through these issues whilst remaining consistent in how they approach topics such as bullying. This will take time. **b. Risk Committee Annual Report** • The Board did not raise any issues from the report which will be reported to TEC from December.	

	c. Fire Report – Quarterly Update • RJ advised that work on the L1 fire alarms starts next week and will go into the next financial year. EL referred to the computer compliance issue – he understood that some computers turn off automatically at 5.30pm; JW advised that most do but the function is switched off on some machines. This can be amended via a software update. **The Board approved the Reports**	
128/17	**20. SINGLE OVERSIGHT FRAMEWORK – NHS PROVIDERS UPDATE**	
	For information only.	
129/17	**21. POLICIES – NONE**	
130/17	**22. 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 – 30th January at 10.30am in the Inspire Centre.		
There being no further business, the meeting was closed at 3.15pm.		