The Queen Elizabeth Hospital King's Lynn
NHS Foundation Trust

Board of Directors (In Public)

Minutes of the meeting held Tuesday 31 July 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 Dickinson (DD)	NED
A Brown (AB)	NED
E Hardwick (EH)	Chief Nurse
N Lyons (NL) from 11.55am	Medical Director
R Jackson (RJ)	Director of Finance & Resources
J Wade (JW) left 11.50am	COO
K Charman (KC)	Director of HR

In attendance:

C Roberts (CR) – item 14	Associate Director of Patient Experience
Mrs V Ashton (VA) – item 14	Patient – for Patient Story
C West-Burnham (CWB)	Head of Strategy
J Hannam (JH)	Associate NED
G Rejzl (GR)	Trust Secretary
L Le Count (LL)	Corporate Governance Officer – minutes

ACTION

INTEGRATED PERFORMANCE REPORT

67/18 1. QUALITY

EL noted the refreshed IPR and asked for any comments on the new format to be passed to CWB.

The Board considered the report and discussion included:

- EL – suggest deferring the discussion on the nursing skills-mix paper as it requires further executive discussion, options appraisal and clear recommendations.
- There were 4 SIs and 1 Never Event in June.
- Safety thermometer performance was just over 95%, slightly below the national average; this was due to a number of catheter infections relating to UTIs.
- The Trust is making consistent progress in relation to falls, particularly those with major / catastrophic harm.
- There has been a slight increase in PUs; the Trust is working to address some facial PUs, caused by equipment.
- IPAC – in June there were no cases of MRSA bacteraemia or C.Difficile reported. The deep-clean has been commenced; Oxborough has been completed and work is on-going on MAU / Terrington Short-Stay.

- MSA breaches related solely to the time window for patients being moved from ITU.
- There has been some progress on clinical indicators across all areas; EH is working with clinical teams / audit department to ensure care is appropriately audited.
- FFT – the Trust is seeing sustained compliance and improvements; ED is challenging but there have been improvements in the response rate, largely due to the work of the new ED matron.
- Complaints – response timeliness has been issue; however, EH is now seeing an improvement. Some themes are repeated over time, i.e. discharge arrangements which can cause problems for patients / families – work is on-going to address the issues e.g. communications, the discharge lounge environment, TTOs etc.
- The Board welcomed NL's report that that mortality rates had not risen over the winter period.
- AB noted that the emergency c-section rate was nearly 25% [against a national target of 15-17%] and queried the cause. EH felt the cause was multifactorial although it may in part be linked to the known challenges within the maternity department. NL advised that increased consultant review of all c-sections had been put in place; he added that some doctors may be reluctant to take risks by letting labour persist. AB also noted that the induction rate was high – NL advised that this may be due to national guidance aimed at reducing neo-natal deaths. NL advised that the instrumental delivery rate was slightly lower, which suggested doctors may currently be opting for c-section for higher-risk deliveries. The Board supported the rigorous medical review of all c-sections.
- AB observed that there was a lack of granular mortality details and queried whether events similar to those at Gosport could happen at QEH - NL acknowledged that the figures produced at Board would not give that assurance; however, mortality is reviewed in depth at the Mortality Surveillance Committee which looks for themes, and benchmarks QEH with other organisations. It was also noted that a review concerning the Trust's controls to prevent a situation like that experienced at Gosport was on the Board agenda.
- IH was pleased with the refreshed IPR, finding the summaries and analysis helpful. He referred to fluid balance data on page 15, querying that in June, only 6 out of 16 areas are green, and queried when improvement would be seen. EH advised that she was pleased with progress made across the wards, apart from 2 areas. This is the 3rd sustained month of increased surveillance in relation to clinical indicators, not solely focussing on fluid / hydration. She added that the fluid balance chart is being adapted for SAU as it relates to a 24hr period and patients are unlikely to be on SAU for that length of time.
- IH referred to mortality and noted that no 'avoidability' had been found. NL advised that 82 deaths had been reviewed but that last year the Trust was not rating against 'avoidability'. More in-depth reviews are now being carried out against a reduced number of deaths. He added that a lack of identified 'avoidability' did not mean there was no learning to be gained from the death. He felt there may be a lack of confidence in declaring 'avoidability' when there is no clear national definition. The Trust and its neighbouring hospitals continue to calibrate results and to work to develop methodologies.
- IP referred to safety thermometer performance on page 3 and queried why it was below the national average – EH advised that data

collection takes place on just one day each month and the two causes related to UTIs and a pulmonary embolus found on that day. Work is on-going across the system to reduce UTIs. **EH will provide more details to the Quality & Performance Committee.** **EH**

- AB referred to the 53 drug errors, 30 of which were administrative errors, and noted that only 2 wards had not reported any harm. NL advised that these were monitored through the Medicines Management Committee and would encourage a low threshold for reporting. NL reassured the Board that there had been no harm reported in any area.
- EL suggested the Quality & Performance Committee review the long-term trend for c-section rates. IH advised that the committee had reviewed these and had received a report on inductions at the last meeting. He noted a slow upward trend. AB suggested the need to clarify the difference between planned and emergency c-sections. **NL advised that a new process for auditing each c-section decision had been commenced – he will bring initial findings in September, then a full report in October.** **NL**

Governor Questions:

- E Corner – the Trust has received patient feedback regarding discharge arrangements for several years, particularly the discharge lounge, waiting for medication and transport and she asked for assurance that improvements will be made. JG felt that several issues related to communication and this may be able to mitigated. The discharge lounge is designed to create flow throughout the day, so patients need to be moved there early in the day and this needs to be communicated to families. He also felt the lounge could be made more appealing. The new initiative, Discharge-to-Assess, includes a discussion regarding discharge with patients / families on admission.
- J Evans agreed with JG regarding the discharge lounge and suggested adding a locker room so patient belongings can be kept safely.
- EL requested an update on progress at the next Board meeting.
- B Lewis felt it was important families were kept informed when the patient was moved to the discharge lounge. JG agreed that this should happen but pointed out that ward staff may not be aware of the planned move. He felt wards should be making greater use of the discharge lounge to improve flow throughout the Trust.
- S Clark agreed with JG that communication was an issue and felt there should be a greater emphasis on 'customer service' at the Trust.

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

68/18 2. OPERATIONAL PERFORMANCE

The Board considered the report and discussion included:

- A&E performance was strong in June and into July, however significant pressures during the last 10 days, including high acuity and increased demand for 1:1 care, had resulted in JW declaring an Internal Incident today.
- Cancer – there has been a relatively strong performance; however, regrettably, the backlog of patients has not yet been cleared. The NHSi Cancer Intensive Support Team (CIST) will be on site from tomorrow to

provide external assurance.

- Diagnostics – the Trust missed the standard in June as EchoTech, the external company, which provides an echocardiogram service to the Trust, cancelled lists on the last day of June, due to staffing issues. The Trust is no longer using their services. JW expects July performance to be back on target.

- IP referred to 18week referral comments and requested a trajectory – JW will include this is next month's report. He felt the standard was still achievable, provided there is an effective use of theatres. IP noted that few theatre sessions started on time – JW advised that this was only one measure of effectiveness and that the theatre list running time is the same, regardless of start time.
- IP queried how many long waiters there were for cancer - JW advised that c60 patients are waiting over 62 days.
- **DD queried whether theatre start times were monitored - JW confirmed they were and will bring theatre metrics to the next Quality & Performance Committee meeting.** **JW**
- **IH queried what the key suggestions from FourEyes were – JW advised that scheduling, ensuring lists were fully booked, and challenging the consultant body regarding the number of patients per list were all potentially beneficial suggestions. JW will report fully to the next Finance and Activity Committee meeting.** **JW**

Governor Questions

- S Clark referred to the 300% increase in operations cancelled at the last minute during the last year (page 28) and queried the cause - JW advised that issues with equipment, staffing issues and operational pressures were the main causes. JG added that during the winter pressures period, patients were telephoned to say there was a risk of their operation being cancelled on the day due to the potential lack of a bed and were given the opportunity to re-book.
- P Tasker queried the role of CIST – JW advised that they would be bringing expertise from other hospitals, looking at the PTL and cancer pathways, and providing assurance regarding monitoring during the pathway. JW is confident that the Trust will be able to tackle the backlog over next 2-3 months.
- EC suggested the Trust should consider the impact of cancellations on patients – JW advised that this will be part of the CIST remit. He assured EC that any patient whose wait reaches 104 days undergoes a harm review by the relevant consultant and no 'harms' had been recorded to date. He was mindful that psychological 'harm' was harder to measure.
- C Monk queried whether use of CIST would incur costs for the Trust - JW advised that this was provided free of charge by NHSi.

<u>The Board noted the Operational Performance update</u>

69/18 3. WORKFORCE

The Board considered the report and discussion included:

- Vacancies have increased to c.12% due to an increase in establishment of 50 posts.
- To date, 33% of agency spend has occurred in only 25% of the year –

this is mainly nurse agency spend. There was some improvement in early July. One area for improvement is the agency cap with only c.20% shifts within the price cap – KC is aiming to reduce this.

- Whilst many organisations report an inability to spend their apprenticeship levy, QEH has plans to utilise the levy to help address workforce issues.
- **IP asked for greater detail appraisal data, adding that despite best efforts, 20% of staff are not receiving an appraisal. KC advised this will go to the Workforce Committee and she will continue to progress.** **KC**
- EL noted that there had been a significant increase in FFT responses but a disappointing amount of feedback was negative. KC advised that it would take time to address the narrative received and establish a change in values and behaviours. **EL felt that the free text gives valuable insight and asked the Workforce Committee to review this.** **KC**
- EL queried the delay in the recruitment process - KC advised that this had been caused by a delay in pre-recruitment checks, which had gone from 60 days to 90 from May-June and she was focussing on reducing this.

Governors' Questions

- P Tasker noted that the medical staff locum bill was nearly £1m and queried whether it could be broken down into consultants / junior doctors. KC advised that she did have that information. There had been a challenging fill-rate of 73% for junior doctors last year but this is expected to be c85% this year. The lifting of the cap on visas will also prove beneficial.
- J Dossetor referred to exit interviews – KC advised that 10-15% of people who left the Trust cited reasons for leaving, which were within the Trust's gift to change, i.e. flexible shifts / secondments. If the Trust was able to reduce turnover this would be beneficial.
- A Walder congratulated the Trust on its use of apprenticeships. He then queried how the Trust was managing staff morale currently. JG acknowledged that some areas were under considerable pressure; the temperature on the first floor of the hospital is very high, making working conditions difficult and the increase in parking charges had alienated some staff. He is working with senior staff to overcome some of these issues.
- C Monk noted that less than a third of apprenticeships related to nursing / healthcare and queried whether there were plans to increase this - KC advised that the next tranche of nursing apprenticeships start in September, and a cohort of nursing associates will also join as part of the apprenticeship scheme. The Trust is working with COWA on projects such as a 6-year pathway covering multiple levels of apprenticeship.

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

70/18 4. FINANCE

The Board considered the report and discussion included:

- EL acknowledged that the finance position reported was very challenging and the Board needed to address issues raised.
- RJ advised that clinical income had been inadvertently under-reported for Month 2. This occurred as the income file had been run early and was lighter than expected by 1 day.
- YTD the Trust has made a control total loss of £9.1m which is £2.8m adverse to the pre-PSF plan
- The main drivers of the slippage are nurse agency and clinical income. There will be a focus on clinical income for the remainder of the year; however, addressing the nurse agency costs is more challenging and the Board needs to consider other actions to address the gap.
- IP queried how secure the funding was for the capital programme - RJ advised that there is some risk as the programme requires loan financing. The capital plan has been prioritised. IP queried whether the roof project was secure - RJ advised that he had been informed on 26th July that the business case had been approved but was awaiting formal approval. The formal outline business case is on the Private Board agenda today.
- IH noted that the hospital was running at full capacity but was adverse on planned and unplanned activity / income and queried whether this had been over-estimated on the plan. RJ felt that the issues related to acuity rather than volume and there had been a level of variability within the plan as not all plans would deliver as expected.
- AB was disappointed with the reported position as this issue had been identified in April and the NEDs had been urged to reserve their full assessment until the end of Q1. He felt that there appeared to be a lack of grip.
- EL agreed that need serious action was required to address the issues.
- DD queried whether the efficiency schemes were deliverable - RJ advised that he will continue to identify mitigating actions and schemes.

Governor Questions

- P Kunes queried whether the additional 50 posts created had been budgeted for - RJ advised that these roles should pay for themselves via increased income; however, a reduction in income means they are not funded and it was a failure of the business case to deliver the benefit.
- A Walder voiced concern regarding the Trust's ability to forecast accurately and queried what assurance the NEDs will seek from the EDs. IP advised that the Finance & Activity Committee are looking at performance against budget / forecast and that the NEDs challenge rigorously and appropriately.
- B Lewis noted that the Trust does not receive funding for patients readmitted within 30 days - EL confirmed that readmission rates and related issues, such as patients being admitted with a different condition and the availability of community services to support demand management had been reviewed in depth at the Quality & Performance Committee.
- E Corner queried whether the NEDs were concerned by the number of purchases of medical equipment being purchased by the Charitable Funds / League of Friends (LoF), which might generally be expected to

be bought by the exchequer. EL advised that he was, and his personal view was that medical equipment should be funded by the exchequer not charitable funds; however if funding is not available from the exchequer, then alternative sources of funding need to be sourced. He added that he was very grateful for the support of the Charitable Fund and League of Friends charities, for their ongoing support.

- IP advised that he chaired a meeting of the Charitable Funds Committee yesterday, acknowledging LoF funding of c.£50k for medical equipment and bids against the General Fund. He agreed that ideally a hospital should not be reliant on charitable donations for equipment but that the QEH is in a challenged position.

The Board noted the Finance update

GOVERNORS' QUESTIONS

71/18 M Bruce raised the issue of patients who are Medically Fit for Discharge (MFFD) and those who are identified as having a Delayed Transfer of Care (DTOC). Currently there are 55 patients who are MFFD and 27 DTOCs as well as 73 patients who are deemed 'super-stranded' (stays in excess of 21 days). He requested more information on these patients in the IPR and queried whether the 'daily indicator' information could be sent to Governors as a weekly, rather than daily report.. JG advised that Discharge-to-Assess should address this issue as once a patient is declared MFFD the Trust will start the paperwork for a full assessment for care to take place after safe discharge. Norfolk residents tend to be discharged quickly with appropriate care; however there are significant problems with Cambs / Peterborough. The Trust should see an improvement in DTOCs numbers by December.

QUALITY

72/18 5. CHAIR'S WELCOME AND APOLOGIES FOR ABSENCE

EL welcomed the Board to the second part of the meeting. He welcomed DD to the Trust, and he thanked the governors for their participation in his appointment.

Apologies were received from M Ashton, D Thomason and C Moore.

73/18 6. MINUTES FROM THE BOARD OF DIRECTORS' PUBLIC MEETING ON 29th MAY 2018 / MATTERS ARISING

- J Evans advised that her husband had suffered with a blocked bowel rather than a blocked valve. She clarified that he had not been in hospital for the whole 6 month period.

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

74/18 7. ACTIONS MONITORING

The Board reviewed and updated the Actions Monitoring Record.

Actions 5, 6, 10, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25 and 26 were considered

complete and were removed from the action log.

See Action Log for further updates.

75/18 8. CORPORATE VISION & STRATEGY

The Board considered the presentation and discussion included:

- JG explained that the purpose of the emerging corporate strategy was to draw together a number of individual plans and demonstrate how they link together and to include a refreshed organisational 'vision' from December 2017.
- The Organisational 'Sandwich' shows what is being brought together, including the development of strategic delivery tools. He explained the need for and progress in embedding an effective quality improvement methodology, an accountability framework and an OD strategy, underpinning the vision and strategy. A soft launch will take place in August, followed by a full launch in September linked with the roll-out of the values / behaviours framework.
- The 'Golden Thread' shows how the strategy will flow and impact team and individual objectives. This is linked with organisational development and accountability.
- The 'pillars' represent a suite of supporting strategies, which help deliver the strategy.
- Quality of care is key for safety and delivering good outcomes / patient experience. For an organisation like the QEH, committed to quality improvement, this needs to be a focus.
- Outcomes have to be measureable.
- Staff elements are linked to the Workforce Strategy.
- Technology / innovation needs to be optimised as a springboard / enabler.
- The final slide demonstrated how everything fits together the strategy suite should be largely in place by September, apart from Estates / IT.
- DD queried how finance and communications fitted into the strategic pillars. JG advised that communications related to values and behaviours 'listen well' and should filter through everything. Finance and the long-term financial model are vital, as none of the elements can operate without financial input.
- DD queried whether the strategic priorities are equally weighted - JG advised that all priorities are closely interlinked and as such get equal standing although the 'top level' is the early priority.
- EL noted that transformation is not featured and felt that the strategy needed to outline what is meant by transformation and how this is achieved.
- GR asked the Board to confirm that it endorsed the direction of travel, which they did.

The Board endorsed the direction of travel of the Corporate Vision and Strategy

76/18 9. DECLARATIONS OF INTEREST IN ITEMS ON THE AGENDA

77/18 10. URGENT ACTIONS (Under Standing Order Para. 5.2) - none

78/18 11. NORFOLK & WAVENEY STP Update

The Board considered the monthly oversight report and discussion included:

- AB noted that block contracts appear to be the preferred direction of travel for the STP; EL concurred, adding that NHSE also appear to be in favour.
- GR advised that 'guaranteed income contracts' were on the Board Development Workshop programme for discussion in September.
- The potential use of the Fermoy unit was discussed; JG is SRO lead for the STP and advised that the Fermoy was seen as an STP asset. It had been considered as a major 'hub' but requires capital to undertake the necessary refurbishment. QEH has suggested creating a hub for integrated care and felt this should be progressed.

The Board noted the STP Update

79/18 12. CEO'S UPDATE

The Board considered the report and discussion included:

- Highlights included the NHS @ 70 events, both locally and nationally, and the CQC visit.

The Board noted the CEO's update

80/18 13. CHAIR'S REPORT

The Board considered the report and discussion included:

- EL noted that while the Government has expressed a desire to put more funding into the NHS, no detail has been seen to date. He felt the funding was unlikely to resolve current financial issues but would potentially identify transformational opportunities.

The Board noted the Chair's Report

QUALITY

81/18 14. PATIENT STORY

- CR welcomed Mrs Valda Ashton who was a patient in June and described her experience of waiting for a vital operation

- VA advised that she was a staunch admirer of the NHS, which had saved her life on several occasions.
- On 23rd March 2018 VA was diagnosed with bowel cancer; on 16th April she saw Mr Khan who gave her a date of 16th May for her operation – this was then brought forward to 9th May.
- VA's eldest daughter took time off work to bring her mother to the hospital, and her other daughter travelled from Spain to be with her mother. VA undertook the necessary preparation for the operation on the day before, and then received a telephone call at 6pm to say the operation had been cancelled as there were no available beds in ITU.

Her daughter had to return to Spain but made many telephone calls to the hospital to secure another date; however, she was unsuccessful.

- VA's son in Australia was concerned and emailed Mr Khan's secretary and JG but did not receive a reply; the only response he received was from the PALS' office.
- VA's daughter emailed George Freeman MP and he looked into the matter. VA then received a new date for the operation, 6 weeks after the original date.
- VA was very positive about the treatment she received from Mr Khan and his team, the anaesthetists and the staff in ITU. She was then moved to Denver ward where she found the staff to be very caring but over-stretched. She advised that sometimes patients did not receive an evening or morning drink as staff were occupied elsewhere and had observed that a drugs-round was completed close to midnight, following an emergency on the ward.
- She was very grateful to the hospital for the care she received and was pleased to advise that she was recovering very well, with lots of beneficial aftercare in place from the Trust. Her main concerns related to the stress caused to both her and her family by the significant delay in rescheduling the operations, and by the lack of response to the numerous telephone calls and emails.
- EL thanked VA for sharing her story and he was pleased to hear that her operation had been successful. On behalf of the Board he apologised for the cancellation and subsequent delay of her operation which, he felt, fell short of reasonable expectations.
- JG also thanked VA and apologised for the cancellation and delay. He assured her that he usually replies promptly to his emails and apologised for the omission – he will look into this. He explained that without an ITU bed the Trust would not be able to provide intensive care for a patient after such major surgery. He was, however, concerned by the 6 week delay – he felt she should have been seen within a fortnight and received appropriate communication.
- **EH thanked VA for her comments, particularly in relation to Denver ward and she will speak to the matron regarding the missed drinks.** She explained that wards are often busy, and as Denver is an acute step-down surgical ward it often experiences high acuity. She added that patients would see a difference between the 1:1 care they receive on ITU and the less-intensive nursing provided by more general wards. **EH**
- AB felt that communications was an issue and the Trust needed to consider the disruption and anxiety caused to patients and their families.
- IH felt that the pace at which the operation was re-scheduled and the poor communications need to be taken seriously by the Executives.
- CR confirmed that she has spoken to Admissions and work is on-going to ensure someone responds to patients on the same day.
- **EL asked EH to follow this up with CR and update in September.**

<u>The Board noted the Patient's Story</u> **EH**

82/18 15. REVISITING THE PATIENT STORY

The Board considered the report and discussion included:

- EH confirmed that investigations remain on-going.

The Board noted the Patient Story update

83/18 16. QUALITY IMPROVEMENT UPDATE

The Board considered the report and discussion included:

- EH explained that focus had been on the CQC inspection and progressing the action plan.
- Since the last Public Board meeting, the Trust had received the 'Well-led' element of the CQC inspection; the Trust had received high-level initial feedback which had been discussed earlier at the Governors' Council meeting.
- Lou Notley had been on secondment from Colchester hospital but has accepted a fixed-term contract for 1 year at the Trust as Associate Director of Patient Improvement.
- The QM team is developing a comprehensive quality improvement plan, not only focussing on items which were highlighted during the inspection.
- EH felt that the degree of confidence in the Trust's response to issues identified demonstrated by the CQC has been largely positive; the Trust is now reporting fortnightly until the end of August when it will report monthly. EH continues to report maternity actions on a weekly basis, and takes part in a weekly telephone call.
- Quarterly Quality Summits are being planned to share innovation / best practice; these will strengthen the governance process throughout the organisation.
- JG will be joint Chair of the QM group with EH.
- Quality Improvement methodology workshops are taking place countywide.
- EL advised that the Trust anticipates the draft report from the CQC to arrive in the first half of Aug and the Trust will have 10 days to respond.

The Board noted the Quality Improvement update

84/18 17. FREEDOM TO SPEAK UP GUARDIAN (FTSUG) update

The Board considered the report and discussion included:

- GR provided the update on activity / referrals in M Ashton's absence.
- Two cases are subject to an investigation; by the end of the week she is expecting to upload Q1 FTSU information to the National Guardian's website.
- C Moore has been appointed Executive Lead for FTSU.
- GR felt it was a matter of priority to let M Ashton concentrate on her NED role, so there will be an interim independent appointment made to the FTSUG role in the next 2-3 weeks.
- EL thanked M Ashton for the work undertaken so far.

The Board noted the Freedom to Speak-Up update

RISK

85/18 18. BOARD ASSURANCE FRAMEWORK (BAF)

The Board considered the report and discussion included:

- GR explained that this was a summary report; once the strategic objectives are agreed the BAF will be refreshed to reflect these.
- GR will invite the Board to discuss the residual risk ratings, following regulatory intervention.
- EL felt that strategic risks were likely to evolve.
- IP considered that the cyber security audit should be added to the BAF as a source of assurance.
- GR suggested that the board reconsiders these when it looks at the BAF in full.

The Board endorsed the Board Assurance Framework (BAF)

86/18 19. CORPORATE RISK REGISTER (>15)

The Board considered the corporate risk register and discussion included:

- NL advised that risks were now expressed more clearly and that the register had been reorganised to reflect the new organisational structure. A specialist from NHSi had been invited to help with risk articulation.
- IH queried how Risk 2306, relating to cancellation of elective cases, dovetails with the FourEyes work - NL advised that the work had been understood and was progressing; JW is likely to be able to update.
- GR advised that M Rose is developing a risk management framework to support decision-making in the Trust, including business cases.
- EL noted that many of the risks, each rated '15' were rated either 'possible' and 'catastrophic' or 'moderate' and 'almost certain'. He felt that these have vastly different consequences and explored whether the mitigation reflected the different outcomes. **NL will take away and consider.** **NL**

The Board noted the Corporate Risk Register update.

REGULATORY AND GOVERNANCE

87/18 20. PERIODIC REPORTS

a. Guardian of Safe Working

- NL explained that the structure of the report is a national template.
- This is the last report to be submitted by C Lloyd (CL) as he leaves the role tomorrow. CL is frustrated as junior doctors do not use exception reporting to allow monitoring to improve their working conditions. QEH is not alone in this – it is a national issue. CL and the Junior Doctors' forum work hard to understand where improvement can be made.
- NL has just appointed a Junior Clinical Director – this is part-time role to improve the leadership team. The role will include holding NL to account to deliver optimum working conditions, and representing the

junior doctors.

- NL felt there was a level of complacency amongst junior doctors concerning the Safe Working reporting arrangements.
- IH queried whether NL was sure that no adverse / covert pressures had been applied to junior doctors to prevent exception reporting. NL was able to provide reassurance that there is no direct pressure – this has been consistently discussed at consultant meetings to ensure it is not happening.
- **IP found the tables on pages 3 and 4 to be confusing - NL will review.** **NL**
- EL noted that the Trust has had issues with junior doctors reporting concerns direct to the Deanery on occasion and felt that if junior doctors are not raising concerns internally, then the Trust cannot address them. NL suggested improved engagement with the Junior Doctors' forum should help.
- JH felt there were a number of assumptions as to why the junior doctors are not engaging but the actions are heavily dependent on the forum functioning correctly; she queried what can be done to improve this. NL advised that the BMA is providing pizza at the junior doctors' meetings which usually improves engagement.

The Board noted the Guardian of Safe Working update

88/18 21. RESEARCH & DEVELOPMENT update

The Board considered the report and discussion included:

- EL felt that the Trust's growing reputation for Research and Development was 'good news' and asked NL to pass on the Board's congratulations.
- NL advised that thanks should be given to the R&D team who consistently 'punch above their weight' both regionally and nationally. IH queried the progress of securing a dedicated research clinic room – NL advised that this is being worked on.

The Board noted the Research & Development update

89/18 22. CYBER SECURITY UPDATE

The Board considered the report and discussion included:

- Dionach will be carrying out a re-evaluation of the Trust's cyber security preparedness at the end of August.
- AB felt that the Trust was addressing the risk correctly. He noted that Microsoft had withdrawn support for Windows XP in 2014 and as such the Trust had received no support for 4 years. It was considered that most systems using XP were 'standalone' and not on the network.
- AB has an introductory meeting planned with M West.

The Board noted the Cyber Security update

90/18 23. POLICIES / ToR - none

91/18 24. REGISTER OF DIRECTORS' INTERESTS

The Board noted the report.

The Board noted the Register of Directors' Interests

92/18 25. BOARD OF DIRECTORS – FORWARD PLAN

The Board noted the Forward Plan

Questions

S Clark referred to the STP report and felt that an innovative use of the Fermoy Unit would be to develop a hub for the voluntary sector.

Date of next meeting of Board of Directors (Public) meeting – 25th September at 11.30am in the Inspire Centre.

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

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