Trust Board Meeting in Public

Held on Thursday 7th February 2019

Lecture Theatre, Education Centre,
Queen Alexandra Hospital, Southwick Hill Road, PO6 3LY

MINUTES

Present:	Melloney Poole	Chair
	Gary Hay	Non-Executive Director
	David Parfitt	Non-Executive Director
	Martin Rolfe	Non-Executive Director
	Christine Slaymaker	Non-Executive Director
	Mark Cubbon	Chief Executive Officer (CEO)
	Chris Adcock	Chief Finance Officer (CFO)
	Paul Bytheway	Chief Operating Officer (COO)
	John Knighton	Medical Director (MD)
	Theresa Murphy	Chief Nurse (CN)
In Attendance:	Lois Howell	Director of Governance and Risk (DGR)
	Emma McKinney	Director of Communication and Engagement (DCE)
	Penny Emerit	Director of Strategy and Performance (DSP)
	Nicole Cornelius	Director of Workforce and Organisational Development (DWOD)
	Ben Goodwin	Divisional Nurse Director (minute 031.19)
	Philip Young	Guardian of Safe Working (minute 046.19)
	Dave Gordon	Committee Clerk (minutes)

Item No	Minute
030.19	**Welcome, apologies and declarations of interest** The Chairman welcomed everyone to the meeting. Apologies were received from Roger Burke-Hamilton (Non-Executive Director) and Inga Kennedy (Non-Executive Director). No declarations of interest were made.
031.19	**Patient Story** The case concerned a 37 year old male, who required hospital care following a major operation whilst in a difficult personal situation (no family at his home, anxious about time off work). He had a recent history of abdominal problems, and eventually arrived at the Emergency Department (ED) in extreme pain. A diagnosis of colon cancer led to surgery; however, the procedure discovered the extent to which this had spread. As a result, the patient was left with a stoma and a considerable wound which required time to heal. The patient's emotional condition was becoming a concern after 6 weeks at the hospital. A detailed discharge plan was put together, involving a period of several weeks to improve his mobility. Meanwhile, work on support for the patient at home was also undertaken. As a result of this work, the patient's condition improved and he was able to return home by Christmas 2018 and as yet has not required any further in-patient treatment.

	The Chair asked why such plans were not routine policy; the Divisional Nurse Director responded that whilst such extensive and intensive support was not required in most cases, focus on treatment could also mean that patients' domestic circumstances were not prioritised. The Chief Nurse added that community work and patient advocacy were vital in such situations. Christine Slaymaker raised the issue of stratifying support given the range of situations encountered and the costs involved; the Chief Executive Officer assured the Board that a series of assessments were conducted upon a patient's arrival, with continual assessment from that point forwards. The Trust also worked with social services to determine any ongoing needs. The Director of Governance and Risk also outlined the Trust's work with veterans, Age Concern and the Red Cross to fulfil these responsibilities to certain groups of patients.
032.19	**Minutes of the last meeting** The minutes of the meeting of 3rd January 2019 were approved as a true and accurate record of the meeting.
033.19	**Matters arising / summary of agreed actions** The Board reviewed the Action Log. Regarding the action arising from minute 188.18, the Chairman of the Finance & Infrastructure Committee asked for support in identifying her opposite number at another Trust with similar Private Finance Initiative (PFI) arrangements, in order to find out more about how other Trusts discharged their PFI responsibilities. The Director for Governance and Risk agreed to assist. Given the fact that Divisional Teams would be presenting to the Trust Board between April and August 2019 as set out in the actions arising from minute 010.19, the equivalent agenda items for Finance and Infrastructure Committee would be suspended. It was noted these discussions would focus on key challenges rather than a granular review of financial performance; as a result, the Finance and Infrastructure Committee may still need financial presentations from the divisions. This would be considered in due course in the light of the Board presentations from the divisions.
034.19	**Notification of any other business** No items of other business were raised.
035.19	**Chair's opening remarks** The Chair wished to extend the Board's gratitude to the Chief Nurse, who would be leaving the Trust before the next meeting. Her work in transforming the service, with particular reference to care, compassion, staff morale and encouraging a culture of openness was noted by the Board. The Chair commented on the pressure experienced by the hospital since the end of Christmas. This year's influenza virus had led to more cases than anticipated and the recent bad weather had added to this level of demand. The Board was committed to providing assistance as appropriate. The Chair ended her introduction by welcoming the arrangement of development days for the Trust Board. This was helping build resilience within the Board, and was also helping bolster their corporate presence and ability to have a positive impact on the wider organisation.

036.19	**Chief Executive's Report** The Chief Executive Officer expressed his thanks to staff across the Trust. The co-operation of diverse teams had been excellent and done much to alleviate the pressures brought by the peak of winter. Once the season had been completed, the Trust would reflect on this year and incorporate the learning into its plans for next year; the Chief Operating Officer was already working on these preparations. However, during January 2019 the Emergency Department had seen over 1,000 more patients than modelling had predicted. Influenza had also hit staff and the community, with rates of infection up 1.5% from the equivalent period in the previous year. Staff wellbeing was being monitored, with teams asked to look out for any members struggling with their health. The CEO raised two other key issues: Exiting the European Union: the Chief Operating Officer was leading on this, with a particular focus on identifying and managing risks. Any such issues identified were reported to the Trust Leadership Team and would be presented to the Trust Board as appropriate. All available national and regional guidance was being followed, with Senior Managers also attending briefing sessions on developments. Chief Nurse Position: The Chief Executive Officer echoed the Chair's thanks for the work of the present incumbent. With regards to recruiting a successor, significant progress had been made. The final panel interviews for the position would be held on 8th March 2019; any interim appointment required was being managed in conjunction with NHS Improvement. Gary Hay asked why modelling had underestimated levels of demand. The Chief Executive Officer assured the Board that this increase was reflected nationally; the winter review mentioned earlier in this minute would include this as an area for investigation. In order to manage these pressures proactively in future, the Trust would need to consider matters such as discharge policy and procedure, out of hospital care and reducing the number of admissions through offering suitable alternatives. The Chair asked the Non-Executive Directors to be particularly focused on seeking assurance that planning for the next winter was excellent and put in place well in advance of time. The Board noted the update.
037.19	**Quarterly Corporate Strategy Update** The Director of Strategy and Performance presented the amended form of reporting, with the update now aligned with the Balanced Scorecard. The Implementation Plan was used to map whether the Trust's actions and their consequences reflected intentions, with supporting enabling strategies drawn from the Trust's overall strategy rather than being stand-alone policies. The Chair sought assurance that this would be used in staff appraisals; the Director of Strategy and Performance confirmed it would. The Director of Communication and Engagement added that this would now need to be communicated consistently across the Trust. Martin Rolfe asked why the risk summary table seemed relatively static; David Parfitt added a request as to whether the pattern of movements for risks could be included in reporting. The Director of Governance and Risk responded that each risk had a target

	date in its own section in the detailed breakdown. However, the issues raised by Non-Executive Directors would be reviewed as part of the Trust's drive to improve its reporting. **Action: DGR** The Director of Strategy and Performance added that the lack of focus on enabling strategies was an area being addressed for the future. Christine Slaymaker asked if there were plans to streamline the management of outpatient services. The Chief Operating Officer responded that an internal plan was being co-ordinated to see if the Trust could operate differently. The Board noted the update.
038.19	**Board Assurance Framework** The Director of Governance and Risk had also amended the reporting format for this document, as previously it had been very lengthy. It should also be noted that, whilst 16 of the overall scores remained static, the reasons for a number of those scores had changed; details of this were available in the detailed working pages on each area. BAF 8 (mental health services) had seen its score rise, as a result of the withdrawal by the provider of a key support service for children and adolescents, and the dilution of dedicated resource within the Trust. Recent developments however (e.g. the reinstatement of Children's and Adolescent Mental Health Services in the Emergency Department) had given the Trust confidence this score would fall before the next reporting cycle. The score of three risks had reduced. BAF 3 (compassionate care) had been reduced in score following a quality review involving external input which had provided significant assurance regarding mitigation of many (but not all) of the Trust's concerns in this area. These key areas featured prominently in the Trust's Quality Recovery Plan. BAF 10 (emergency preparedness, response and resilience plans) had also been the subject of external scrutiny that supported the Trust's downgrading of the risk, whilst BAF 21 (performance against key cancer standards), although it had been added relatively recently was proposed for removal from the BAF given that it had reached the target level of risk. Meanwhile, two new risks were proposed for addition to the BAF. These were the Trust's year-end financial forecast (BAF 24) and United Kingdom departure from the European Union (BAF 25). Gary Hay asked why BAF 23 (governance systems ineffective in the delivery and monitoring of improvement) had increased during the course of the year. The Director of Governance and Risk responded that, although governance systems were apparently improving, 'Never Events' continued, which indicated that learning was not being embedded as required. As a result, two pre-existing risks (governance systems and processes for improvement) had been amalgamated. It was intended that the work on divisional structures and meetings would reduce this risk in the foreseeable future. Improvements in this area would be reported through the Integrated Performance Report and via the Quality and Performance Committee. David Parfitt raised the issue of 'deep dives' into BAF entries; the Director of Governance and Risk replied that these were not currently scrutinised by any one committee given their cross-disciplinary nature. David Parfitt suggested that

	consideration may need to be given as to how the Board could be assured on these matters; the Audit Committee was proposed as a possible solution to the matter. Currently, the Trust Leadership Team was viewing the whole framework on a quarterly basis. Martin Rolfe posited the reporting of risks that were either not meeting their target dates or receiving higher scores for internal audit. The Director of Governance and Risk assured the Board that there was an annual internal audit review of the framework. Christine Slaymaker stated that pressures on the hospital (as mentioned in minute 036.19) could lead to performance issues. As a result, any inspectorate may question the decision to remove BAF 21 from the framework at this stage should it subsequently require re-inclusion. The Chief Operating Officer assured the Board that the 62 day target had been prioritised in the reporting quarter. Reassurance had also been provided that short term availability for oncology would not be affected. However, the Board was not content to remove BAF 21. The Board resolved that BAF 21 would remain on the Board Assurance Framework at this stage, and agreed to add BAF 24 and BAF 25 to the Framework.
039.19	**Integrated Performance Report** The Chair welcomed the new reporting style, which provided greater assurance to the Board. The Director of Strategy and Performance thanked the Board members (Roger Burke-Hamilton and Martin Rolfe) and staff who had provided support in updating the document, which now provided clarity on the purpose of the report and sought to bring the most appropriate data sources to the Board. The measurement for improvement approach (as discussed at Board Workshops) had been part of the redesign, with NHS Improvement also involved. Future work would focus on improved presentation of graphs and using the data to evaluate whether noted variations should give rise to concern or were the result normal variation. The objective here was to create a summary page which would guide the Board as to where data required further interrogation. Data and commentary were now also standardised. The Chair asked if it was possible to provide historical data in this new format to allow the Board to understand changes in provision and outcomes. The Director of Strategy and Performance assured the Board that all previous inputs had been kept, with the text in the report used to provide an improved narrative which highlighted key issues. The Chair also highlighted the repetition of slides; whilst justified, this may be an area where the report could be amended (although they applied to a range of issues). Martin Rolfe welcomed the new style as a move from raw data to knowledge; the next step would be to generate insight from the document. It also helped with understanding the impact of actions on other, seemingly unrelated areas. David Parfitt also welcomed the fact that the Trust Leadership Team and the Board were now using the same working document, but questioned if more was needed on workforce. Christine Slaymaker also asked if the balancing measures identified were the right ones, and whether the right benchmarks had been chosen (e.g. did Trusts have similar PFI arrangements). The Board noted the updated report.

040.19	**Quality and Performance Committee feedback** The Committee Chair (Martin Rolfe) reported on the meeting held on 25th January 2019. The recovery trajectory on the 4 hours access standard had not been met overall for the month, but it was noted that there had been considerable pressure on the Emergency Department during the reporting period. Meanwhile, the Committee had cautious optimism regarding cancer services. The 21% reduction in the number of pressure ulcers was a particular highlight, whilst the quality review in January was welcomed, as was the commitment to repeat the process on a quarterly basis. The Committee was also encouraged by the self-referral to the Human Tissue Authority. Despite the initial incident being relatively minor, the decision to self-refer was an indicator of a culture of openness, and the lessons taken from the investigation had been very beneficial; the Committee had asked if other departments could benefit from a similar process. Meanwhile, the maternity survey had highlighted local community access as an area for improvement. The Board was asked to agree to a change in reporting procedure; namely, that the Quality Recovery Plan should report to the Quality and Performance Committee only, rather than to both the Committee and the Trust Board. The Committee would then escalate matters as appropriate with the Board. The meeting on 21st February would take an item on the action plan in place in gastroenterology services; this would report back to the Board on 7th March 2019. Clinical effectiveness was also an area for action. The Board resolved that the Quality Recovery Plan would now be reported to the Quality and Performance Committee rather than to both the Committee and the Board, and noted the Committee's feedback.
041.19	**Safety, quality and operational performance report analysis** The Medical Director introduced the section, which focused on learning culture. Since January 2019, weekly Clinical Directors' Huddles had taken place which included face-to-face discussions on risks, events and operational matters. In addition, the Serious Incidents Panel pilot had been applied in 3 divisions, with the remaining division to adopt the new approach imminently. These innovations had led to learning being more consistently and thoroughly identified than the Trust had previously experienced. In addition, clinical forums had been used to discuss the potential for incidents which had not yet taken place and how to intercept these issues. This new process had been discussed at the Board Workshop in January 2019. The Trust had experienced around 1,500 significant learning events (in line with expectations) and would continue to review metrics to ensure insight was taken from these. Martin Rolfe sought clarification as to who assessed the level of harm involved in such incidents; the Medical Director stated that these were based on the reporter's initial declaration and subsequently reviewed by the Patient Safety Team. Whilst the level of harm may be altered on review, the graph present in the Integrated Performance Report would not reflect this. The Chief Nurse added that real time management of quality issues was mitigating risk across the Trust. However, patterns involving the number and type of falls experienced by patients would require further analysis. Twice weekly SitRep (Situation Reporting) meetings were monitoring clinical standards; patient experience would also be introduced as a metric at these soon.

In terms of medicine management, the Medical Director informed the Board that there had been no incidents leading to moderate or severe harm in the last 3 months. Meanwhile, in terms of medicine reconciliation, although the Trust was not meeting the standard (80% of in-patients to receive a medicines reconciliation review within 24 hours of admission), it was above the national median.

Performance on Health Care Associated Infection was relatively good; the balancing measures demonstrated the effectiveness of prevention and control measures in place. No significant outbreaks of norovirus had occurred, although one such incident of a similar infection (astrovirus) had taken place; this seemed to be a national trend. The infection prevention team's quick and aggressive approach to their work was having a clear impact. However, the peak of influenza was expected over the coming days; this year's strain was H1N1-type, which could have a severe impact on those affected. Thus far, it had been a contributory factor in a small number of deaths within the Trust (and the primary factor in one death). Some staff had also been affected; initial suspicions that a mutation had occurred would be investigated, and could account for the limited impact of this year's vaccination.

Metrics for deteriorating patients were being developed; previously, the focus had been on Commissioning for Quality and Innovation (CQUIN) standards. However, the Trust wanted to ensure that any metrics used were driving appropriate quality improvements. There were currently no balancing measures in this area, and these would be created to reflect the drive for improvement.

The Chief Operating Officer noted the pressure on the Trust over winter and the assistance provided by advanced planning; winter 2019 – 20 was already being anticipated. Occupancy had been a major theme, with the Trust trying to create a sustainable ward-by-ward culture of improvement, with increased discharges and appropriate arrangements in place. However, for this to embed work on alternatives to hospital care would require prioritisation.

In the last two – three weeks, admissions had risen whilst discharges (both simple and complex) had been stable. As a result, performance in ED had declined and pressure on ambulances had increased. The identified priority was to increase the level of complex discharges whilst maintaining the rate of simple discharges. The Chief Executive Officer added that the Trust had moved from being a national outlier with regards to ambulance holds to being in line with standards. Lost ambulance time had reduced by 90% whilst there were no waits in ED exceeding 12 hours.

The Chief Operating Officer informed the Board that all eight cancer standards were now being met. An action plan for ophthalmology was now in place, with its impact on the outpatient waiting list to be assessed. Meanwhile, fortnightly meetings were being held to generate an action plan for gastroenterology.

Martin Rolfe noted that, whilst reporting dealt with absolute numbers it did not offer proportional or per capita rates. The Chief Operating Officer assured the Board that this level of detail was present in the work undertaken with external consultants; Martin Rolfe felt that such detail could highlight the Trust's level of improvement clearly.

David Parfitt asked if the pressure to discharge was compromising safety and leading to an increased level of readmission. The Chief Operating Officer assured the Board that all complex discharges required sign off by multiple practitioners and that internal teams were monitoring readmission rates closely. The Chief Nurse added that some patients who had been considered as "complex discharges" had been supported after their departure from hospital to ensure their safe reintegration into the community. The

	Medical Director also stated that readmission cases were considered as part of the learning events system discussed earlier in this minute. The Board noted the update.
042.19	**Quality Recovery Plan** The Director of Governance and Risk introduced the latest version, which provided a commentary up to December 2018. This had already been scrutinised by the Quality Recovery Group and the Quality & Performance Committee. The accuracy of reporting had increased, and highlighted the fluctuations in performance and the impact of winter pressures on the Trust. There were no clear indications as to when CQC would visit the Trust; however, the organisation needed to be ready for such an eventuality. Key to this would be moving monitoring from the recovery phase of the Trust's development to 'business as usual'. As resolved in minute 040.19, the Quality Recovery Plan in its entirety would no longer be presented to the Trust Board. Christine Slaymaker asked if this was the appropriate time to take the Quality Recovery Plan away from the Board. Given the potential for the Board to act as preparation for the CQC inspection, and the fact that the Board could run the risk of becoming detached from the reality of the hospital's work, she asked if the initial headline section of the report could be attached as an appendix to the Quality and Performance Committee report. This was agreed. **Action: DGR** David Parfitt asked if the focus on Section 29a meant that the report was not covering other areas. The Director of Governance and Risk agreed that this focus would change as part of the wider move towards making such work 'business as usual' as mentioned above. David Parfitt agreed that such a change would provide a more holistic view. The Board noted the Plan.
043.19	**Learning from Deaths** The Medical Director introduced the item, based on the findings of the Mortality Review Panel. This Panel reviewed all deaths within the Trust, with the proportion deemed to be possibly avoidable very low. Statistics indicated the levels of such cases were comparable with other Trusts operating similar systems; the threshold for avoidable deaths was designed to avoid under reporting. Figures could also be skewed by the fact that sudden deaths could often initially be seen as avoidable, but transpire not to be so upon further investigation. Analysis had indicated that advance care planning had improved. However, the Trust was aware that the paperwork used in the process of identifying and analysing avoidable deaths needed to be more concise and isolate the real priorities in reporting. Gary Hay sought assurance that this was now moving towards being business as usual. The Medical Director assured that this was the case, with the challenge now being to make the new system sustainable. The Board noted the report.

044.19	**Lessons Learned – Gosport War Memorial Hospital Independent Panel Report** The Director of Governance and Risk updated the Board, advising that the Trust had reviewed the Independent Panel's report. Although the Panel had not made any recommendations for individual health organisations, the identified concerns about practice and culture at Gosport War Memorial had been reviewed and their relevance or otherwise in the Trust had been assessed. Whilst it was accepted that it was unlikely to be possible to mitigate against the impact of individual practitioners with malicious intent, the Board was asked to acknowledge the implementation of arrangements and safeguards to minimise the risk of avoidable deaths. Gary Hay stressed the importance of medicine management and the need for vigilance. David Parfitt also raised the potential for small hospitals or single practitioner GP practices to be dominated by individuals because of size, appropriate checks and balances. The Board acknowledged these points. The Board accepted the report.
045.19	**Workforce and Organisational Development performance report analysis** The Chair of the Workforce and Organisational Development Committee (Gary Hay) informed the Board that the Committee's scheduled meeting had not taken place in January 2019 as a result of the deferment of a series of reports to February's meeting. The Director of Workforce and Organisational Development highlighted the work underway concerning the review of establishment and recruitment. A national campaign had been launched, with the Trust particularly focusing on student nurses and overseas candidates to reduce the number of vacancies. 55 candidates from other nations had so far been recruited, with another 99 expected between April and June 2019; this was in line with the Trust's objective of reducing the vacancy figure for nurses to zero by the third quarter of 2019 – 20. In other metrics, the temporary workforce had reduced. It was noted that 30 staff currently were absent with flu (which amounted to 11% of the total absence rate across the Trust). Turnover had decreased to 12.7% whilst the percentage of appraisals had risen to 80.2% (albeit still below target). The Senior Leadership Development Programme had been launched at the end of January 2019 and phase 2 of the Culture Change Programme was also underway. The Chair sought assurance that the zero target for nurse vacancies was realistic; the Chief Executive Officer responded that the overseas campaign was as vigorous as any he had seen. The Chair agreed that current funding opportunities made the timing of this initiative appropriate. Christine Slaymaker raised concerns regarding the increase in funded workforce numbers. The Director of Workforce and Organisational Development responded that this was the result of the implementation of a number of business cases and finalising the establishment (e.g. inclusion of Junior Doctors). Christine Slaymaker was not assured that changing targets were conducive to budgetary balance; David Parfitt noted that this had risen by over 10% in the last year. The Chief Executive Officer noted these comments, and advised that funding would be locked down once the review of the establishment had been completed. However, Christine Slaymaker sought greater assurance on the level of expenditure on specific areas (e.g. nursing, doctors). The CEO

	assured the Board that once the establishment had been locked down and signed off for 2019 – 20, departments would be held to account against these final figures; the Board and the CEO agreed that this would need to be checked at Board level in the future. The Board noted the update.
046.19	**Trust Guardian of Working Hours Report** The Guardian of Safe Working Hours introduced the report, which was based on exception reports. As there were concerns that Education Supervisors could be seen as remote by Level 1 and Level 2 doctors, reporting was now to nominated consultants. It was anticipated that this would reduce the times for which reporting was waited, and therefore may increase the number of cases recorded. In order to meet the target of a maximum of 72 working hours in any 168 hour period, rota software needed to check compliance with the new agreed basis. The upgrade in software which would allow for this was awaited and as yet had no specified date. The Trust was optimistic that this would be in place for the trainee doctor changeover in August 2019. The Trust estimated that this would lead to a change in approximately one third of rotas. There had also been an increase in the reliability of data for locum shifts. The Chief Executive Officer asked if it was possible to include the number of shifts filled in reporting, as well as the number not filled. The Director of Workforce and Organisational Development agreed to investigate how this could be calculated. **Action: DWOD** The Chief Executive Officer also noted how ensuring working hours were protected was a major element in workforce stability. As a result, he invited the Guardian of Safe Working Hours to become involved in working on service area gaps and risks for the workforce. The Chair supported this as an element in ensuring the best support for patients. Gary Hay asked if Junior Doctors were reluctant to report issues. The Guardian of Safe Working responded that there were no obvious indications that this was happening. However, it could not be ruled out that some who wished to progress to Consultant level were unwilling to be seen as 'troublesome'. It was acknowledged that an anonymised App could circumvent such concerns (however ill-founded). Martin Rolfe asked if communications could emphasise the link between fatigue and errors in treatment. The Guardian of Safe Working Hours acknowledged that the information received from exception reporting, and the higher estimates generated by the General Medical Council raised some concerns as to whether the current system accurately reflected reality. The Board accepted the report.
047.19	**Finance and Infrastructure Committee feedback** David Parfitt updated the Board as an attendee of the Committee's last meeting. The main focus of the meeting had been around current financial performance, the forecast outturn for the current year, the 2019 - 20 Control Total and facilities. The financial information covered by the Committee would be covered in minute 048.19. The Board noted the feedback.

048.19	**Financial performance report analysis** The Chief Financial Officer updated the Board on the position for 2018 – 19. At present, the deficit for the year stood at £30.3 million and the revised year end forecast deficit of £34.8m seeks to restrict further deterioration to £4.5m across Quarter 4. This relative improvement in performance had been based on all divisions submitting and re-confirming their plans to improve their net expenditure trends. Quarter 4 contains the majority of the impact of the elective activity recovery plans and other one off benefits. All of these issues are set out in the Trust risk and opportunities scheduled which is revised weekly at the CEO led Weekly Financial Recovery Meetings, Trust Leadership Team and monthly by the Finance and Infrastructure Committee. The reported income position shows a position variance but is skewed by PbR exclusion income which is a pass through item for which the opposite effect is in expenditure accounts. David Parfitt raised the pressures on healthcare during quarter 4 (which included the peak of winter and the Trust's ability to deliver improvement in this context). As a result, there may be a need for all pledges made in the prediction for Quarter 4 to come to fruition in order to meet £4.5million estimated deficit target. The Chief Financial Officer agreed that the prediction was less risk averse than previous forecasts. The Chief Financial Officer advised that Divisional forecasts had taken account of their plans for winter although extended periods of pressure would increasingly challenge delivery plans. The Board noted the update.
049.19	**Audit Committee feedback** The Chair of the Committee (David Parfitt) stated that the Committee had applied pressure in cases where target dates for implementation of recommendations made by the Internal Auditors had not been met. This approach was working well. In addition, the Committee had considered the draft Internal Audit work programme for the coming year and had sought to ensure an effective balance of audit activity between patient-facing services and back office functions. The next meeting in late March 2019 would consider the Clinical Audit Plan and the final Internal Audit plan for next year to ensure consistence between them. The Audit Committee had also reviewed the draft Reservation of Powers Policy and Scheme of Delegation and recommended that the Board adopt the revised policy. The Board noted the Committee's update.
050.19	**Reservation of Powers and Scheme of Delegation Policy** The Director of Governance & Risk presented the revised policy, which as indicated above the Audit Committee had recommended for adoption by the Board. Christine Slaymaker noted sections 4.9 and 17 b) and c). Her concerns related to mapping the workforce against affordability and control of pay. She also asked if the section on tenders (4c) should involve more people being present at the opening of bids as a safeguard.

	Given these concerns, these sections would be reviewed again, and the outcome of further consideration would be included in the Chief Executive Officer's report for the next meeting as an appendix. **Action: CEO / DGR** The Board resolved to adopt the revised Reservation of Powers and Scheme of Delegation Policy as recommended by the Audit Committee, apart from sections 4.9 of the Reservation of Powers Policy and paragraphs 4 c), 17 b) and 17 c) of the detailed Scheme of Delegation.
051.19	**Directors' and Non-Executive Directors' reflections on the meeting** The Chair welcomed the celebration of positive trends in this meeting's papers and also the level of detail. In particular, the new Integrated Performance Report had delivered a real improvement in the presentation of information and the Board's ability to interrogate it. The dovetailing of Committee and Board work was also assisting with ensuring that the focus of work was correct. Overall, the conversations had moved on from the need for substantial effort to tangible improvements. Additionally, the Board had moved on to assessing patient outcomes and was covering the areas in its remit (e.g strategy, performance, probity). The balance between offering positivity and challenge was also being reached more appropriately. However, both Non-Executive Directors and Executives raised the issue as to whether all papers published in the public session were suitable for wider distribution, or should be included in the private session.
052.19	**Record of attendance** The record of attendance was noted.
053.19	**Opportunity for the public to ask questions relating to today's Board meeting** No questions were raised by the public.
054.19	**Any other business** There were no further matters raised.
055.19	**Additions to Board Assurance Framework and Risk Register** No additions to either the Board Assurance Framework or Risk Register were requested.
	Next Trust Board **Date of Next Meeting:** Thursday 7th March 2019, 9.30 am in the Lecture Theatre.