Milton Keynes University Hospital NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

DRAFT Minutes of the PUBLIC session of the 71st Meeting of the Milton Keynes University Hospital NHS Foundation Trust Board of Directors. Held on Friday 4th March 2016 at 10.30 am, in Lecture Theatre of the Education Centre at Milton Keynes University Hospital NHS Foundation Trust.

CHAIRMAN:
Baroness Margaret Wall (MWa)

CHIEF EXECUTIVE:
Joe Harrison (JH)

NON-EXECUTIVE DIRECTORS:

Frank Burdett (FB)	-	Chair of Charitable Funds Committee
Jean-Jacques de Gorter (JDe)	-	Chair of the Quality and Clinical Risk Committee
Robert Green (RG	-	Chair of Audit Committee
David Moore (DM)	-	Chair of Finance & Investment Committee
Simon Lloyd (SL)	-	Non Executive Director
Tony Nolan (TN)	-	Chair of Workforce & Development Assurance Committee

EXECUTIVE DIRECTORS:

Kate Burke (KB)	-	Director of Corporate Affairs
John Blakesley (JB)	-	Deputy Chief Executive
Kate Burke (KB)	-	Director of Corporate Affairs
Jonathan Dunk (JD)	-	Director of Finance
Ogechi Emeadi (OE)	-	Director of Workforce
Emma Goddard (EG)	-	Director of Service Development
Lisa Knight (LK)	-	Director of Patient Care and Chief Nurse
Martin Wetherill (MW)	-	Medical Director

IN ATTENDANCE:

Michelle Evans-Riches (MER)	-	Trust Secretary
James Bursell		Patient Experience Lead
Anne Thysse		Head of Midwifery

There was six Governor, three member of staff, two members and newly appointed Non Executive Director of the public in attendance.

1.1	**Apologies for Absence**
	There were no apologies for absence.
1.2	**Declarations of Interest**
	There were no declarations of interest.
1.3	**Minutes and matters arising from the last meeting held on the 7th January 2016.**
	The draft minutes of the meeting held in public on the 7th January 2016 were presented. **Resolved: That the draft minutes of the meeting held on the 7th January 2016 be agreed as a correct record of the meeting.**
1.4	**Matters arising/Action Log** The Board of Directors received the action log, which provided updates on actions agreed at previous meetings. The following updates were given at the meeting:- **Action Ref 288 Chief Executive's Report** An analysis of the safety attitude questionnaires completed by maternity services staff had been completed and would be reported to the Maternity Improvement Board and Trust Board. It was agreed that this action was now closing, **Action Ref 314 Orthopaedic Never Event** The Trust continued compliance at 100% of the WHO checklists and operational audits were being undertaken**.** The CCG had challenged compliance on parts of the WHO checklist and these were being examined. **Action Ref 315 Delivering Excellence in Maternity** The issue of non-attendance by Monitor at the Maternity Improvement Board had been raised by a progress review meeting and it was anticipated that attendance would improve. It was agreed that this action was now closing. **Resolved: That the action log as updated at the meeting was received.**
1.5	**Draft Minutes of the Council of Governors Meeting held on the 12 January 2016**
	The draft minutes of the Council of Governors meeting held in public on the 12 January 2016 were presented. **Resolved: That the draft minutes of the Council of Governors meeting held on the 12 January 2016 be received.**

2.	**Chair and Chief Executive reports**
2.1	**Chairman's Report** The Chairman's report included in the agenda was considered. **<u>Resolved</u>: That the Chairman's Report be received.**
2.2	**Chief Executive Report**
	JH gave a verbal report and highlighted the following:
a.	**Electronic Patient Record** The second phase of the EPR which was the upgrading of software had been successfully completed and this required a huge amount of support from a number of operational services across the Trust. Detailed plans for the further phases to improve clinical care and realise the benefits of the system were now being developed.
b.	**Junior Doctors Strike** It had been announced that there would be a 48 hour industrial action by junior doctors on the 9th and 10th March. JH informed the Board that he was one of 20 Chief Executives who signed a letter to the Secretary of State for Health stating that they believed that the contract being offered was fair and reasonable for doctors in acute hospitals. The Secretary of State for Health had decided to impose the new contract and had cited the letter signed by the 20 Chief Executives as support. JH stressed that he did not support the imposition of the contract and had told the junior doctors at the Trust of this.
c.	**Referral to Treat (RTT)** JH informed the Board that in the last year there had been a 12% increase in A&E attendances and 6% increase in the number of ambulances which transported the sickest patients to the hospital. This was significantly greater than the increase across the NHS and had an impact on emergency and elective care.
d.	**Financial Planning** Monitor had been on site for two days to undertake a review of the draft annual plan 2016/17. The finance and operational teams had responded to queries from Monitor. The Board were informed that it was likely that there would be a reduction in the underlying deficit position for the Trust.
e.	**Healthcare Review** Further work was underway in preparation for the public consultation. Implementation requirements were also being developed e.g. what physical capacity was needed for the two new organisations. MWa expressed her thanks to the Finance Team for the preparatory work undertaken prior to the Monitor review and stated that the Monitor Review Team had expressed their appreciation for the thorough information provided. JDe asked what form the junior doctors' strike was taking and JH responded that it was a 48 hour strike for elective care only and emergency care would be provided.

	JH emphasised that the relationship with local junior doctors was outstanding and the junior doctors' focus was to ensure that patients were provided with safe care. DM asked what was anticipated to be the proportion of junior doctors taking industrial action nationally. JH responded that nationally 98% of junior doctors had voted to take industrial action. On previous strike days all junior doctors who were rostered for emergency work had completed their shifts. A review of specialty elective work had been undertaken but it was anticipated that junior doctors would follow the BMA lead.
f.	**Draft Trust Objectives 2016/17** JH presented the draft Trust Objectives 2016/17 and invited comments from the board members before the Trust Objectives were reported to Board in April 2016. **Action 316: Michelle Evans-Riches** **<u>Resolved:</u> That the Chief Executive's report be received.**
3.1	**Patient Story**
	MWa welcomed Anne Thysse, Head of Midwifery, to the meeting and emphasised the importance of the Board to hear a patient's story as patient care was at the heart of all board decisions. Anne Thysse (AT) informed the Board that when she took over the post of Head of Midwifery there were a number of complaints regarding the maternity service and she dealt with this complaint from Sonia regarding her experience whilst having her first baby at the hospital. AT stated that every labour was different and there was no indication how each labour would progress e.g. some labours last up to four days and this is quite common in the labour for a first baby. AT spoke to Sonia regarding her experience and Sonia informed her that at 3am in the morning her waters broke and she phoned the labour ward. She was advised to stay at home but if she had any further concerns to ring the labour ward. At 9am Sonia rang the labour ward again as she was still losing water and they invited her to attend the hospital where she was checked and it was determined that everything was normal and she was advised to go home. This was appropriate advice as women progress better in labour in at home. Sonia left the hospital and went shopping. During this time the contractions intensified and at 4pm she came back to the hospital. Following examination she was informed that her cervix had started to open and AT explained to the Board that the cervix had to be 10cm dilated to enable delivery of the baby. Sonia had attended the pregnancy assessment unit and had told the midwifery staff that she didn't want to go home. The midwives advised her to take paracetamol for the pain; however, Sonia did not want to take the paracetamol. On reviewing the patient record Sonia took paracetamol at 8pm and the midwives had written that she was being observed and the midwife felt that everything was progressing okay. However Sonia informed AT that she did not feel this. She explained that she was in some pain and was sick in the bathroom and unfortunately it had gone everywhere. Sonia stated that she had gone to the desk and

	told the staff that she had been sick in the bathroom and had made a bit of a mess. The staff responded by asking if Sonia had cleared it up. Sonia was disappointed and angry with the midwife and student midwife with this lack of care they provided to her. Sonia explained that there was a change in shift and that there was a noticeable improvement in the care provided. She was put on a monitor and was informed that she was ready to give birth. Sonia stated that her experience on the labour unit could not have been more different and was excellent. She was provided with gas and air to alleviate the pain and stated that the staff, including the student midwives, were excellent and the baby was delivered safely. AT stated that women remember their birth experience and an adverse experience can affect the bonding between mother and baby. After receiving the complaint from Sonia, AT spoke to the midwife concerned who was upset and had not realised how she had come across to the mother. The midwife also stated that she had not documented everything, as there were two labours progressing simultaneously and she was risk assessing both. AT also spoke to the student midwife who was mortified by Sonia's complaint and had written an insightful letter of apology to the patient and had changed her practice. AT stated that when she arrived at the Trust pethidine was not given routinely as pain relief and this practice had been introduced on the ante-natal ward to provide mothers with strong pain killers whilst in labour. AT stated that pain relief was essential for mothers in labour, as relaxed labours were preferable for mothers and babies. KB asked whether the Trust regularly engaged with the Maternity Liaison Committee to ascertain patient experience. AT responded that they met on a monthly basis and she as Head of Midwifery met with the chair of the Committee separately on a monthly basis. There have been a number of improvements initiated e.g. food was now available to mothers returning to the wards even late at night. An intercom had been installed from ward 9 to 10 to the neo natal unit to enable mothers to visit their babies. Following the outcome of a survey of families visiting hours for grandparents had been relaxed. A survey for mothers was now being undertaken to identify any improvements to care. In a response to a question by BG, AT stated that the lessons learned from this complaint were shared with midwifery staff and the midwife and student involved had changed their practice. **RESOLVED**: **That the patient story be received and that Sonia be thanked for allowing her story to be shared with the Board.** AT left the meeting.
3.2	**Patient Experience Programme**
	Doctor James Bursell gave a presentation to the Board on the Patient Experience Programme and highlighted the following :-

	A Patient Experience Team had been established including himself as a consultant, a patient experience manager and a communication support. The patient experience programme was being developed and the following was highlighted: • Patient experience was one of the top three trust objectives and was all encompassing of patient and family contact. • Picker Inpatient Results had been published for 2015. There have been improvements in four areas – ward cleanliness, toilet cleanliness, and doctors talking over patients as if they weren't there and there had been a decrease in the number of responders who ranked patient experience less than 7 out of 10. • There had been little change in the number of responses to the Friends & Family Test. Key actions that could be taken included rapid patient feedback to ensure that patients believe that their feedback was important to the Trust. • Feedback to relevant staff in a timely manner to ensure that there had not been a long time lapse. • Patient Experience Champions would be appointed. • Personal responses to social media postings. • There needed to be a cultural change with a strong message from the Board that patient experience was important. • A non-punitive manner of providing feedback to staff was required to improve patient experience. • The trust had submitted a bid to the Maternity Experience Challenge Fund and was awaiting an outcome. BG asked if email was used to obtain patient feedback and in particular for the Friends and Family Test. JBu responded that the current provider for FFT did not use email or SMS texting and there were anonymity issues regarding email. In response to a question by MWa, JBu stated that information left by patients on wards was not included in the FFT, as the FFT required responses to specific questions regarding whether you would recommend the hospital for care. TN stated that the Trust received lots of data e.g. from "I Want Great Care" and nursing metrics and why had patient experience not improved. JBu responded that the response rate to patients experience questionnaires was not reflective of the demographic. Equally the feedback loop took too long to enable the service to take swift action. JH added that the Board had focussed on improving Outcome 1 – Improving Patient Safety and Outcome 3 – Improving Clinical Effectiveness and was now nationally one of the best performers. The challenge now was to focus on patient experience. In addition there had been a marked investment in the hospital environment and the estate. However, the Board would need to decide whether to make further investment to increase capacity. DM asked if patient experience focus groups were held to gather patient feedback. JBu responded that some services e.g. paediatrics and cancer have specific focus groups and the information was used to improve services for patients. The patient experience programme would ask heads of service to identify the best mechanism to obtain patient feedback on their experience. **<u>Resolved</u>: 1. That the Patient Experience Programme presented be noted.** **2. That the Patient Experience Programme be discussed in detail at a future the**

	Board Development day. **Action: 317 Michelle Evans-Riches**
3.3	**Quality Priorities 2016/17**
	LK stated that the Quality Account 2015/16 was being drafted and the three quality priorities would be : • A reduction in the frequency and severity of medication errors. • Improve the identification and management of the deteriorating patient. • Improve the management of patients with Sepsis. The Trust was awaiting detailed guidance before measurable targets for these indicators were set. These would be reported to the Board in April 2016. **Action 318: Lisa Knight** **<u>Resolved</u>: That the Quality Priorities 2016/17 as outlined to the Board be noted and a further report submitted to the Board in April 2016.**
3.4	**Quarterly Mortality Report**
	MW introduced the Quarterly Mortality Report and informed the Board that the trust had the 4th best hospital standardised mortality rate (HSMR) in the country and was the top performer in comparison to peer Trusts. The Mortality Group met on a regular basis and had identified that there were no areas of concern. The Trust had not received any alerts regarding HSMR or SHMI. There had been an increase in the number of inter-uterine deaths and these were being analysed but the trust remained within the normal range of perinatal mortality which was currently 3.7 per thousand births compared to 4.8 per thousand births in 2015. Weekend mortality rate was higher than weekday but was in line with national performance. MW stated that statistically patients who were admitted at weekends had a higher acuity level. The Quality and Clinical Risk Committee had asked for an analysis on the impact on mortality of the junior doctors' industrial action and this will be reported to the Committee. **<u>Resolved</u>: That the Quarterly Mortality Report be received and accepted.**
3.5	**Serious Incident Report**
	MW informed the Board that the trust was compliant with reporting all SIs to the Clinical Commissioning Group by the deadline and had not incurred any penalties. The trust had met with the CCG at the end of the quarter SI assurance meeting and the CCG had reported that it felt assured by the evidence provided and congratulated the Trust governance team on the robust process for SIs. The Serious Incident Review Group (SIRG) met on a weekly basis to review SIs and

	the action plan. Learning from SIs was disseminated across the Trust. Near miss plenary sessions were being held where three presentations were given to multi-disciplinary audiences on the learning from near miss events. BG asked if human errors regarding not reading policies were recorded on the HR files of the individuals. MW stated that regular communications were issued to all staff regarding the necessity to be up to date with knowledge of policies e.g. the consent policy. Any non-compliance was raised through the annual appraisal process. **<u>Resolved</u>: that the Quarterly SI Report be received and accepted.**
3.6	**Nursing Staffing Update**
	LK presented the report and informed the Board that the Lord Carter report had recommended a new tool for nursing staffing evaluation and guidance on this new tool was awaited. Fill rates for nursing staff were now within the Monitor trajectory level and the cap for nursing agency was currently only for nursing staff. However, it was anticipated that this would be replicated across all staff groups. A government announcement was expected within the next two weeks as to whether nursing would remain on the UK Shortage Occupation List which enables the trust to recruit nurses from outside the EU countries. Monitor and NHS bodies had made representations to the government that it was important to retain nursing on this list. The trust was awaiting this announcement prior to going to the Philippines for recruitment for nurses and in particularly midwifery and operating theatre nurses. DM asked for clarification of ward 4 staffing levels as it appeared that there were fluctuations. LK stated that ward 4 was the Paediatric Assessment Unit where staff were flexible to accommodate activity. DM asked if evidence based tools were used to assess the staffing requirements in certain areas. LK responded that these were used for inpatient areas; however, ward 4, the Paediatric Assessment Unit, replicated childrens'services where there were seasonal peaks in activity and staffing was adjusted accordingly. **<u>Resolved</u>: that the Nursing Staffing update be received and accepted.**
3.7	**Quality and Clinical Risk Committee**
	JDe presented the report of the meeting of the Quality and Clinical Risk Committee on the 22nd January 2016 and highlighted the following:- • The trust continued to improve the interrogation of SIs and the reports contained greater detail of issues such as category, location, age of patient etc. The link between complaints and SIs was also identified. • The Committee were assured that improvements had been made in sharing learning of near misses and serious incidents. This was undertaken through newsletters, team meetings and focus groups. • Reports continue to improve in providing more thorough information for the Committee • The Committee had requested further information by specialty on HSMR and SCHMI.

	• The Committee received an update on progress against the stroke service action plan and will continue to receive reports at each meeting. • The Committee were informed of a pilot undertaken to improve take out medication for patients on discharge. This successful pilot was being rolled out across the Trust. In response to a question by TN, JDe responded that the Committee had asked for details of progress against clinical audits and an update on the deployment of the actions. The internal audit on clinical audits process were presented to the Audit Committee and the next Quality and Clinical Risk Committee. **<u>Resolved:</u> that the Quality and Clinical Risk Committee Report be noted.**
4.1	**Month 10 Performance Report**
	JB introduced the report and stated that activity levels had been high and this was evidenced through indicators regarding A&E, bed occupancy and ambulance handover. LK informed the Board that there had been an increase in the number of grade 3 pressure ulcers, with 3 being recorded on the ambulatory care unit which were all on patient heels. Discussions had taken place with the nursing team on this ward regarding the care requirements of emergency admission patients, as this ward was predominately used for surgical patients. The surgical division leadership team had identified that it would be beneficial to have a medical officer on the ambulatory care unit to deal with emergency admission patients. DM stated that the trust was breaching its target regarding the over 75 year old ward moves after 10pm at night and asked what was the trust was doing to rectify this. JH explained that when there was good patient flow through the organisation patients could be moved at an appropriate time from A&E and the assessment medical unit to the ward. However, the trust had been seeing a particular peak of patients between 4 and 8 pm particularly following GP referrals. This precipitates moves late in the day and the trust does not have sufficient additional capacity to reduce the number of moves. In a response to a question by DM, JB stated that the average age of a patient on the ward was 77 and the average age of a person being admitted was 60. JH reiterated that the performance indicator regarding patient moves after 10pm was very important regarding patient experience. CH added that every effort is made by operational teams to restrict the number of moves at night. In response to a question by BG, JB stated that the 2016/17 performance targets would be reported to the April Board. **Action 319: John Blakesley** JH and CH gave a presentation entitled Referral to Treat (RTT) and highlighted the following: • There had been an increase in GP referrals and certain specialties had seen a peak in referrals. The Trust was speaking to the CCG regarding this and what action could be taken by the CCG to control referrals.

	• A graph was presented which indicated that there was a rapidly increasing backlog for 18 week waits. JH added that in 2015/16 there had been an increase of 3500 to 4000 GP referrals. However, the back log had only increased by 900. This reflected that the organisation was coping well and had absorbed 75% of referrals. • However, there was a restriction on the amount of additional activity the Trust could absorb both in physical capacity and staff resources JH reported that nationally there were a growing number of organisations uncovering previously unidentified patients on waiting lists. The trust had been examining the waiting lists since November 2015 and did not anticipate finding more elective patients. JH reminded the Board that there had been no additional spare capacity for this winter and due to the increasing demand the Executive were scoping the provision of additional capacity for winter 2016. TN asked if patients had a choice of provider and were informed of the length of the waiting list and whether the trust could choose to close its waiting list. JH responded that Milton Keynes was a growing city and the community expected the services provided locally to grow. The trust did not want to send patients to other providers and wanted to provide services for the Milton Keynes community now and in the future. JB added that a consultant could not refuse to take a patient referral and any request to do so would need CCG approval. Both GPs and patients had access to the e-referral system which gave information of up to six different locations and the waiting times for each to enable the patient to make a choice about on-going treatment. The trust also had comparable waiting lists as local hospitals. JDe requested that the Board remain sighted on RTT waiting lists by specialty and that there was no loss of focus when a patient breaches 18 weeks. CH responded that there were detailed weekly meetings to track patients and patients were treated in order, unless the patient requested a delay in treatment. LK added that certain patients were put on urgent pathways e.g. cancer patients had a 2 week wait. **<u>Resolved:</u> 1. That the Month 10 Performance Report be received and accepted. 2. That RTT information by specialty and details of the longest wait by specialty be included in future performance reports.** **Action 320: John Blakesley**
4.2	**Month 10 Finance Report**
	JD presented the month 10 Finance Report and highlighted the following: • The trust recorded an in-month deficit of £2.5M which was £0.5M better than plan. • The trust was £1.6M better than plan year to date with a cumulative £29.6M. • The year-end forecast had been amended to £31.8M deficit which was consistent with the Monitor agreed funding. It was £4.4M better than the original planned deficit of £36.2M. • The £13.6M capital programme had been committed and significant spend was required in the remaining months to ensure that the capital was entire used.

	JD highlight the board assurance framework risks regarding finance and highlighted the following: • **Agency** - the nursing trajectory to reduce agency spend was on track and in month 10 the trust recorded an 18 month low of £1.5M for nursing agency spend. However, Monitor were reducing the agency nursing rates further in April 2016 which would be a challenge for the trust and may increase the number of breaches. • **CCG funding** – Referral to Treat penalties remained a risk for the trust for 2015/16 and 2016/17 until the backlog was reduced. • **Department of Health Funding** – with the reduced deficit the trust did not require additional funding for 2015/16. Monitor had undertaken a two day review of the draft annual plan 2016/17 this week and the outcome was awaiting. • **CIP** - £7m of efficiencies have been delivered year to date, however, there still remained risks for the delivery of the full £8.4M target. MWa stated that it was Jonathan Dunk's last meeting as Director of Finance and thanked him for his excellent financial leadership and his transparent reporting to the Board and the Finance and Investment Committee. The trust relationship with Monitor had improved thanks to the credibility the trust had gained from achieving the financial plan over a number of years. **Resolved: that the Month 10 Finance Report be received and accepted.**
4.3	**Finance and Investment Committee**
	DM presented the Finance and Investment Committee report and highlighted the following : • **Board Assurance Framework** – the Committee reviewed in detail the Board Assurance Framework Risks relating to its remit at each meeting and had determined that there were no additional risks to be added. • **Agency spend** - continues to be a challenge and the Committee were focussed on improvements in the Bank to further reduce nursing agency spend. • **Capital Programme** – the Committee expressed concern regarding the amount of spend required in quarter 4 to achieve the committed capital programme. Assurance was provided that each scheme had been reviewed and would be delivered by the 31st March 2016. • **Digital Solutions** – the Committee received a presentation of various projects within the digital solution work stream which changed processes and improved patient care for the Trust. **Resolved: 1. That the Finance and Investment Committee report be noted.** **2. That the Board receive a presentation on digital solutions at a Board development day.** **Action 321: Emma Goddard**
4.4	**Charitable Funds Committee Report**
	DM presented the Charitable Funds Committee Report and highlighted the following:

	The Committee expressed concern in the decline in income which currently stood at 86% of plan. Milton Keynes was a growth area with a lot of opportunity to raise charitable funds from the community and business which the trust must tap into. The Committee received an outline of the fund raising plan and this would be presented to the Board in May 2016. **Action 322: Kate Burke** **<u>Resolved:</u> That the Charitable Funds Committee Report be accepted.**
4.5	**Update on Estate Development**
	JB gave a verbal report on the estate development and highlighted the following: **A.** Main Entrance – a listening event had been held for stake holders to provide comments on the main entrance development and the outputs of the event had been sent to the designers. The detailed design was expected by the middle of March and subject to the appropriate approvals building work was anticipated to commence in the summer of 2016. **B.** Cancer Centre – the strategic outline case for the Cancer Centre will be reported to Board in April 2016. **Action 323: John Blakesley** MacMillan had completed the feasibility study. An outline business for the aseptic suite where chemotherapy drugs were prepared would be presented to the Board in 2016. **Action 324: John Blakesley** **C.** Radiotherapy - Oxford University Hospital plans to provide a radiotherapy unit on the Milton Keynes site were not developing at present. **D.** Car Parking – Solutions to problems with car parking for 2016/17 would be presented to the Board as part of a proposal. **E.** Academic Centre – the chimney had been removed from the site where the academic centre would be built. Planning permission had been submitted to Milton Keynes and it was expected construction would commence following planning permission in July 2016. **F.** Common Front Door - the outline business case for the common front door would be presented to the Board in May 2016 as part of the trust's obligations to Monitor. **G.** Ward Expansion - an outline business case was being prepared with a modular building provided on site being recommended as a short term solution. **H.** Cage Store - A cage store was being provided adjacent to the main stores which would reduce the need to have transportation cages in corridors.

	I. Off Site Office Space – a short list of potential sites for offsite office provision was being considered. **J.** LED Lighting – LED lighting was being installed to replace strip lighting through the trust and the first stage along the corridors to entrance 6 was completed. JH stated that this was the commencement of a significant undertaking and helped deliver Objective 10 on sustainability. JH said that the NHS as a whole was under significant financial pressure. Nationally it was reported that there was £1.8 billion of new money allocated to the NHS. However it was forecast that there would be a deficit in the NHS of £2.9bn at the end of this year. There were also changes to national insurance contributions which would cost the NHS £1.8 billion in 2016/17. The NHS has been informed that there would be less capital money available in 2016/17 and the Board would have to consider innovative approaches to fund additional capital schemes. **Resolved: That the update on Estate Development be received and noted.**
5.1	**BAF**
	KB introduced the BAF and informed the Board that the BAF would be revised following adoption of the new Trust objectives and would be reported to the Board in May 2016. **Action 325: Kate Burke** In response to a question from JDe regarding BAF Risk Reference 4.1 regarding delivery of targets, KB stated that performance against actions to reduce RTT waiting lists would be reported to the Quality and Clinical Risk Committee in April 2016. JH stated that the BAF should reflect the strategic risks for the organisation to achieve its Trust Objectives and it would be a challenge to access capital to treat patients particularly given the rise in activity. **Resolved: that the BAFF be received and accepted.**
5.2	**Workforce Development and Assurance Committee Report**
	TN gave a verbal report of the Workforce Development and Assurance Committee which met on the 25th February 2016 and highlighted the following: • BAF risk inability to retain staff was scrutinised in detail and formed a large part of the agenda. • The Committee were given headlines from the staff survey which indicated a continuation of the positive trajectory for the trust. • Staff Experience – the Committee received a health and wellbeing report which identified ways to support the health and wellbeing of staff and this was also mentioned in the staff story. • Leavers' Information – the Committee requested more information on why staff were leaving the trust to identify actions to be taken to reduce this. • Workforce Planning – the Committee were informed of the strategic work being undertaken regarding recruitment. The trust encountered demographic

	challenges to the recruitment of staff and the workforce plans were key to ensuring that the trust has inappropriately skilled workforce. JDe stated that Lord Carter's report identified new staffing deployment metrics and asked when these would be implemented. JH responded that further clarify of these metrics was required and would be reported to the Workforce Development and Assurance Committee. **<u>Resolved:</u> that the Workforce Development and Assurance Committee Report be noted.**
6	**Martin Wetherill Vote of Thanks**
	MWa stated that this was Martin Wetherill's last Board as the Medical Director before he started his new role as lead for the trust working with the University of Buckingham. The Chairman paid tribute to the work Martin had done as Medical Director and the assurance he had provided to the Board. Martin ensured that everything he did was patient focussed and the Chairman thanked him for the notable difference he had made to the Board and to the Trust. **<u>Resolved:</u> that a vote of thanks be recorded for Martin Wetherill Medical Director for his hard work and dedication to the Trust.**

The meeting closed at 11.50am
Michelle Evans-Riches,
Trust Secretary
14 March 2016