TRUST BOARD PUBLIC MEETING
Wednesday 10 January 2018
11.00am – 14.30pm
Tony Burgess Room, Corn Exchange, The Pavement, St Ives, Cambridgeshire, PE27 5AG

Members:

Nicola Scrivings	Chair
Gill Thomas	Non-Executive Director
Geoff Lambert	Non-Executive Director
Oliver Judges	Non-Executive Director
Richard Cooper	Non-Executive Director
Dr Anne McConville	Non-Executive Director
Matthew Winn	Chief Executive
Anita Pisani	Deputy Chief Executive and Director of Workforce and Service Re-Design
Mark Robbins	Director of Finance and Resources
Dr David	Vickers Medical Director
Julia Sirett	Chief Nurse

In Attendance:

Taff Gidi	Assistant Director of Corporate Governance
Karen Mason	Head of Communications
Lisa Milner	Patient Involvement and Experience Lead (item 1)
Joanne Greenslade	Rehabilitation Instructor

Apologies:

1	**Patient Story**
1.1	The Chair welcomed the patient, Lisa Milner and Joanne Greenslade to the meeting.
1.2	Lisa Milner introduced the story and noted that the theme of the story was about patient centred care.
1.3	Patient A shared their story including her journey to self-referral into the Dynamic Health service, waiting times for her first appointment and transfer into group sessions led by Joanne Greenslade. Patient A also shared some previous negative experiences of using other providers in the health service in the past and how her experience with the Dynamic Health service was positively different.
1.4	Nicola Scrivings inquired whether Patient A felt that discussing her status as a transgender person was handled with respect and empathy by staff in the Trust's Dynamic Health service. Patient A confirmed that her experience had been positive.
1.5	Patient A also described her experience of being part of the group sessions. She complemented Joanne Greenslade for how well she handled the sessions. The environment in the sessions was positive and supportive from all participants.
1.6	Lisa Milner explained that the patient was a little concerned about participating in the gym sessions. Therefore, the exercise instructor had worked with her 1-to-1 in preparation. Nicola Scrivings inquired how many 1-to-1 sessions the patient had. Patient a responded that she had one session and then she joined the group.
1.7	Nicola Scrivings inquired how long Patient A would be having the gym sessions for. Joanne Greenslade explained that it depended on their rehabilitation. This was part of the initial discussions when they were transferred to the group sessions. In general, patients attend for 6 weeks with an option to attend once or twice a week. Patient A was attending twice a week. Joanne Greenslade explained that patients are generally referred to local community gyms. However, Patient A was due to continue to with group sessions for another 6 weeks to give her the right tools to transition to self-management.
1.8	Nicola Scrivings inquired whether the service would see all self-referred patients. Joanne Greenslade explained that they would have an initial assessment with a physiotherapist and

	then a treatment plan would be agreed which could be self-management at home, group sessions or 1-to-1 sessions with a physiotherapist.
1.9	Richard Cooper inquired whether there was something the service could have done differently to provide even better care. Patient A responded that it would be helpful to have storage lockers in the gym and also a dedicated changing area with showers. The Trust would need to be mindful of providing changing facilities that are transgender friendly. Nicola Scrivings acknowledged that this was an important point to consider when designing facilities for healthcare provision. This would need to be included as part of the Trust's people participation approach. Joanne Greenslade concurred that it was important to provide storage facilities.
1.10	Patient A responded to Julia Sirett's inquiry by explaining that there were currently a wide range of experiences for transgender patients across the healthcare system. She noted that the ideal scenario would be for all clinicians to treat each person as a human being. In the Dynamic Health service, Patient A felt confident enough to disclose that she was transgender and there was no judgement from staff.
1.11	Nicola Scrivings inquired from Joanne Greenslade whether the good practice demonstrated was cultural in the organisation or down to the staff that Patient A interacted with. Joanne Greenslade explained that it was cultural, with the team working together to deliver high quality care for our patients.
1.12	Matthew Winn noted that the use of group sessions was a new model and therefore the Trust was starting to redesign the facilities to match this new model of care. He highlighted that the Trust was due to begin work to refurbish the gym in Peterborough. It was important to ensure that this work included provision of storage facilities in the gym. **Action: Mark Robbins.**
1.13	Joanne Greenslade added that it was important to ensure the gym had the right equipment, the equipment was up-to-date and was regularly serviced. It was agreed that the Director of Finance would review this outside the meeting and ensure equipment and facilities issues highlighted were addressed. **Action: Mark Robbins.**
1.14	Anne McConville inquired how easy it was to transition patients to other gym facilities. Joanne Greenslade explained that some patients chose to use their own gym or to workout at home. The service would discuss with each patient their individual needs and present them with options to suit.
1.15	Geoff lambert noted that there was a lot of information available on various platforms for people to use to self-manage their conditions. The challenge was having specialist direction on which resources were the right ones. Joanne Greenslade also explained that the Dynamic Health service now had its own YouTube channel and had started developing its own videos to provide a resource for patients to self-manage.
1.16	Nicola Scrivings thanked patient A and Joanne for sharing the patient story. She commended the team for the positive patient experience showing good patient centred and responsive care. Nicola Scrivings noted the recommendations in the cover paper and highlighted that the Trust also needed to include patients in the development of future new builds.
2	**Chair's welcome, apologies and additional declarations**
2.1	There were no additional declarations of interest.
3	**Minutes of previous meeting, actions and matters arising**
3.1	Anne McConville clarified that her point on minute 3.2 was to ensure that data on learning from deaths included child deaths data which was dealt with under a separate process. Matthew Winn explained that the Trust's mortality review process was about adults' deaths. Child deaths were dealt with under a different process. The Trust would include any learning identified under the multiagency process for reviewing child deaths as part of the Trust's learning from death approach.
3.2	Geoff Lambert clarified that 5.8 should be Buckinghamshire Healthcare Trust not university.
3.3	Gill Thomas noted that since she had not been at the last meeting, she had not had the opportunity to share her thoughts on 4.5 about penalising staff that were not up-to-date with their mandatory training. She challenged whether this approach was inconsistent with the Trust's values. She inquired whether a better alternative would be to reward teams who were up-to-date with their mandatory training.
3.4	Minutes of the previous meeting were approved subject to the changes discussed above. The action log was reviewed and completed actions discharged. **Action: Taff Gidi**
3.5	David Vickers provided a verbal update on action 1.10 to on ensure services were internally collaborating and coordinating care where patients use multiple children's services provided

	by the Trust in Cambridgeshire. He reported that there was ongoing work on improving collaboration. However, he noted that no progress had been made on the quality improvement fellowship because this was dependent on availability of funding and finding someone who was interested in the fellowship.
3.6	On action 5.11, Anita Pisani explained that an SPC chart covering a 2 year period had now been produced and would be circulated to all members outside the meeting.
3.7	On action 4.19, Matthew Winn reported that the Trust had agreed to change its approach to DBS checks in response to the challenge from the Board. The workforce team were now working with staffside representatives on implementing this.
3.8	On action 11.8 to review the assurance map with the relevant Chairs and Executive leads, Taff Gidi explained that meetings that had been scheduled over the Christmas period had been cancelled due to staffing issues. These were now in the process of being rescheduled. In addition, the assurance map had also been reviewed at the audit committee.
3.9	On Actions 11.11 and 11.12, Karen Mason confirmed that the videos had now been reviewed and there were good lessons to be drawn from both.
4	**Trustwide Quality Report**
	Guardian of Safe Working Hours
4.1	Nicola Scrivings welcomed Dr Jorge Zimbron, the Trust's Guardian of Safe Working Hours. Dr David Vickers explained that this was a new role under the new Junior Doctors contract regime. The post was supported by the Director of Medical Education.
4.2	Dr Zimbron briefed the Board on the key responsibilities of the Guardian of Safe Working Hours and highlighted the key messages from his report including: o Positive feedback from all trainees he had met with. This was also reflected in the General Medical Council survey. o Exception reporting and intelligence from the Junior Doctors Committee are other ways of identifying if there are any issues.
4.3	There are no significant areas of concern to report with regards to safe working. Dr Zimbron highlighted other concerns that had been raised which had an impact on morale of junior doctors including: o Pay issues – ensuring the paperwork was completed on time o Quality of service from the medical staffing team
4.4	Areas of good practice identified included: o an excellent training experience within the Trust. o most trainees report going home on time and working within the role specified by their work schedule. o Junior Doctors Committee attendance
4.5	Anita Pisani reported that actions had already been taken to address the issues relating to medical staffing including recruiting additional resources. The new process had been used for the new trainees who started in December 2017 and it had worked well. A quarterly performance meeting had also been setup for the Deputy Chief executive, the Medical Director and the Senior HR Business Partner to review performance against the service level agreement.
4.6	Anne McConville inquired whether the Board received any updates on medical vacancies in a systematic way. Anita Pisani responded that this was included in the bi-annual workforce review although this did not include an analysis of the impact. In addition, this provided a global view and was not broken down into individual services. Locum expenditure was reported through the finance report.
4.7	It was agreed that the Trust would review whether to introduce a system similar to Cambridgeshire and Peterborough NHS Foundation Trust and how this would be reported to the clinical operational board. **Action: Anita Pisani/Jorge Zimbron/Taff Gidi**
4.8	Dr Vickers inquired whether there was an NHS England requirement to report medical vacancies in this way. Dr Zimbron responded that this was not a requirement, but this approach was important for providing context to the data.
4.9	Matthew Winn inquired whether Dr Zimbron had a way of meeting with other trainees within the Trust who were not based in Cambridgeshire and whether this could be done through a technology solution rather than having to travel for face to face meetings. Dr Zimbron responded that he was happy to arrange teleconferences or video conferencing with other trainees. **Action: David Vickers/Jorge Zimbron**
4.10	Dr Zimbron noted that trainees were currently underreporting any staffing issues and this

	made it harder to get a full picture of any issues. However, the current rate was an improvement from the last quarter. Dr Vickers explained that trainees were being encouraged to report through the Junior Doctors Committee.
4.11	Responding to Gill Thomas, Dr Zimbron explained that the report covered quarter 2 (Aug – Sep 2017). Dr Zimbron was to produce a quarterly report for the Board as well as an annual report. It was agreed that Dr Zimbron would not need to attend every time his report was presented. He was to agree with Dr Vickers when it would be necessary to attend including to present the annual report.
4.12	Anita Pisani noted that issues relating to junior doctors were currently on the national agenda and issues relating to junior doctors were covered through other processes.
4.13	Nicola Scrivings highlighted the importance of being able to monitor trends. It was agreed that future reports would include trend analysis. **Action: Jorge Zimbron**
4.14	Dr Vickers commended Dr Zimbron for the good work since coming into post. He noted that Dr Zimbron had designed the system used to collect safe working hours data.
	<u>Quality Report</u>
4.15	Julia Sirett highlighted the key messages from the quality report including the serious incident in Breckland locality relating to the professional judgement of a Health Visitor and mandatory training target of 95% that had been met.
4.16	Anita Pisani reported that in June 2017, the Trust had been awarded Disability Confident Employer status. This was valid for 2 years. Nicola Scrivings inquired about the assessment process. Anita Pisani explained that this was based on a self-assessment and then an audit by the accreditors.
4.17	Anne McConville inquired whether the Trust made reasonable adjustments for staff. Anita Pisani noted that the Trust had made reasonable adjustments in the past when required.
4.18	Taff Gidi briefed the Board that the Trust had commissioned DisabledGo to conduct a review of our sites, develop access guides and provide guidance to assist in addressing potential accessibility improvements, increasing the impact of refurbishment work and informing estates' strategies. This work was aimed at improving the experience of service users and staff with mobility impairment, learning disability, sensory impairment, dementia or mental health when using our facilities. An implementation plan was in place and this work was expected to be completed in July 2018.
4.19	David Vickers discussed the learning from deaths section of the report including a review of the data from quarter 1 and quarter 2.
4.20	David Vickers also described the ongoing work to collaborate with acute Trusts in Luton to improve the support provided to bereaved families. Matthew Winn and Dr Vickers had also met with the hospice in Bedfordshire to work together on learning from death.
4.21	Matthew Winn inquired how the Board would get assurance on learning from death. Julia Sirett explained that a paper would be presented to the Board in March 2018 on the findings from the report. It was agreed that the paper would include sources of assurance for the Board. **Action: David Vickers/Julia Sirett**
4.22	Matthew Winn inquired whether future reports would include a breakdown by team or locality to allow for analysis of whether there are any hot spots or whether further investigation was required in relation to specific staff. Anne McConville noted that this would be difficult to do. Dr Vickers concurred that the Trust would need to do more work to develop the system before that level of detail could be provided.
4.23	David Vickers explained that there was a possibility of analysing which clinicians last had contact with the deceased and whether death was expected, but cautioned that it would be difficult to use this to attribute death. Oliver Judges noted that it was important to understand what we do not know and what information we could not get.
4.24	Julia Sirett explained that the learning from death screening tool did not include a full review of all clinical records. Anita Pisani inquired how information relating to individual practitioners could be gathered. David Vickers responded that the system was not setup to assess individual practitioners. Matthew Winn added that the Board was not asking for a change in the mortality review policy, but for a system that could identify red flags and any practitioners whose practice caused concern, using the data. Dr Vickers noted that such a system would be very useful, but he was unable to confirm whether that could be developed at present. It was agreed that Dr Vickers would continue to work with other peers and national organisations to identify ways for further analysis of learning from death information.
4.25	Anne McConville explained that the learning from death process was designed, in part, to

	provide understanding for families when there was an unexpected death and how this was reviewed.
4.26	Anne McConville commended the management team for meeting the complaints 25 day target in November 2017.
4.27	Gill Thomas challenged whether the Board could get assurance on safe staffing from the information included in the report noting that the information provided focussed on what would be done in the future to address the concerns raised rather than what was already being done to mitigate these concerns. Nicola Scrivings noted that some assurance was received through the clinical operational boards using tools like QEWTT. In addition, Anita Pisani also highlighted the overspend in children's Acute services in order to ensure safe staffing levels.
4.28	Geoff Lambert inquired about the 'Tops and Pants' survey. Julia Sirett explained that the Trust was utilising different ways to capture service user feedback. 'Tops and Pants' was used in paediatric units to capture feedback from children and young people.
4.29	Anita Pisani briefed the Board on the ongoing work to implement SystmOne mobile. She noted that this was in response to the connectivity concerns raised by various teams. This would allow staff to access SystmOne when offline and then updated the record as soon as the system was reconnected to the internet. Matthew Winn added that a number of connectivity concerns had been raised recurrently by various teams. Some of these concerns were outside the Trust's control e.g. mobile phone connectivity in certain areas.
4.30	Geoff Lambert inquired how the fill rate for SCBU could be over 100%. Julia Sirett explained that this was calculated based on staffing e.g. where 1-to-1 supervision was required.
4.31	Gill Thomas inquired about 'think pink'. Anita Pisani explained that it was an initiative to put in place a process for flagging to paramedics that a patient was known to community services and therefore they would make contact with community services before taking the person to A & E where possible. Matthew Winn noted that this should be a key element covered in 'the one approach' when Bedfordshire children's services transfers into the Trust in April.
	Quality Improvement and Safety Committee
4.32	Anne McConville updated the Board on the key issues from the committee.
	Quality Strategy
4.33	Nicola Scrivings inquired whether the safeguarding improvement project was based on any specific concerns. Julia Sirett explained that the review would assess whether there was adequate resourcing. In addition, it would also assess the different support teams get including teams with embedded safeguarding support to learn lessons on what works best in different teams. Matthew Winn explained that the goal was to understand the optimum way of providing safeguarding support to all our teams.
4.34	On standardisation, Nicola Scrivings inquired whether any consultations would be undertaken. Matthew Winn responded that this was about reducing unwarranted variations and having more consistency. David Vickers noted that this was a similar approach to NICE guidance.
4.35	Richard Cooper inquired about people participation. Julia Sirett explained that the approached had been signed off by the Board and would be reporting through a new Board subcommittee to be established from April 2018. It was agreed that The Chair and the Corporate Secretary would discuss the Terms of Reference outside the meeting ready for approval in March. **Action: Nicola Scrivings/Taff Gidi**
5	**Finance**
5.1	Mark Robbins flagged the main highlights from the report. He noted that cumulative cost improvement plans delivered at the end of month 8 were below target. The cash position was better than reported following a payment received from Cambridgeshire County Council.
5.2	Richard Cooper inquired about schemes that were behind and how the Board could be assured that these would deliver. Anita Pisani explained that the Trust was confident the target would be met non-recurrently this year, but this would impact on next year. Mark Robbins added that some schemes e.g. children's services move had been delayed.
5.3	Nicola Scrivings inquired about the £350k which had not been spent in Peterborough. Mark Robbins explained that this capital expenditure related to Rivergate refurbishment and would now run over into the next financial year.
5.4	Nicola Scrivings inquired whether the Norfolk HCP underspend could be used in Breckland locality. Gill Thomas noted that the underspend was largely due to recruitment challenges. Anita Pisani responded that the Breckland locality had successfully recruited a number of staff who had just completed their induction.

5.5	On aged debtors, Gill Thomas challenge why some public sector bodies were not making payments within 30 days as required. Mark Robbins explained that in some instances, this was due to a lag in invoicing. Matthew Winn noted that the Trust should analyse which debtors over the last 12 months had not made payments on time. Mark Robbins responded that in many cases, this was because of the cycle of when the payments are made so would show some debtors paying consistently at a certain point in the cycle.
5.6	Matthew Winn highlighted that cost improvement plans for 2018/19 should now be included in the report. In the case of Ambulatory Care, 2019/20 was also being developed and should therefore could be shown. **Action: Mark Robbins**
5.7	Anita Pisani reported that the Trust had received additional winter money in Luton..
5.8	Matthew Winn challenged whether the Trust should set a stretch agency cap target which was better than the NHS Improvement target. Mark Robbins noted that this would need to be set by division. **Action: Mark Robbins**
5.9	Gill Thomas inquired whether the Trust agency target 2018/19 would remain the same even though the Trust had acquired new services. Mark Robbins explained that this would remain the same unless a revision was agreed with NHS Improvement.
5.10	Richard Cooper inquired how the target was set. Mark Robbins explained that NHS Improvement had reviewed actual spend which was £5.2m and set a target for the Trust to reduce this to £3.3m.
5.11	Anita Pisani briefed the Board on the ongoing work to improve use of the bank including a new national push for a collaborative bank. The Trust was actively engaged in the discussions about collaboration, but was unlikely to be part of it because it would cost the Trust more. Matthew Winn added that this was because the Trust did not have the same issues as acute Trusts and therefore our approach to bank was different. Mark Robbins noted that the Trust's use of bank staff had been improving consistently.
5.12	The Board discussed the letter received relating to unallocated 2017/18 Sustainability & Transformation Fund (STF) and agreed that the Trust would not be delivering a higher surplus target than budgeted for, in part, because it would be difficult to alter our plans at this late stage and difficult to justify to our staff delivery of a higher surplus while the Trust was asking services to make more efficiency savings.
6	**Key Issues and escalation points from Clinical Operational Boards**
	Ambulatory
6.1	Richard Cooper briefed the Board noting that the last meeting had focussed on the 3 escalation points which had been recurring for a while. There was also positive news on express testing.
6.2	Gill Thomas noted that it would be helpful if the report included information on how far the unmet KPIs were from target in the report especially if they were recurring. It was agreed that future reports would include details of the variance and how long a KPI had not been met. **Action: Taff Gidi**
	Luton
6.3	Geoff Lambert noted that he had received an update from the Luton Service Director on the position as at the beginning of January 2018. BCG backlog had come down significantly. Audiology was largely as a result of staffing issues.
6.4	The harm free indicator had been discussed extensively at the last meeting.
6.5	Cost improvement plans for 2018/19 were proving challenging and would be a key focus of future meetings.
6.6	The Trust had provided significant support to local acute Trusts to help them meet their targets and manage winter pressures. Anita Pisani added that there was extreme pressure on new year's day and the day after. The directors who were on call had provided support and the Trust's operational staff stepped up to help including some staff who cancelled their days off.
	Children and Young People
6.7	Gill Thomas noted that the appraisal rate in Cambridgeshire Children's services was 71.9%. Further review was to be conducted at the next meeting. **Action: Anita Pisani**
6.8	The committee had also reviewed the two risks scoring 15 and above. Matthew Winn explained that one of the risks related to Provide, a third party contractor who provided the child health information data set, which gives new birth visit information to allow 14 day visits.
6.9	Matthew Winn inquired whether the next meeting would also receive an update on the KPIs that were not meeting targets and a plan for how these would be on target at year end. It was

	agreed that the lead executive would discuss with the service director and ensure this was included in the next clinical operational board report. The update was to also include action plan on appraisals. **Action: Mark Robbins**
7	**Key Issues Reports from other Board Sub Committees**
	Strategic Change Board
7.1	Nicola Scrivings summarised the key issues including an update on Bedfordshire transition.
	Estates Committee
7.2	Gill Thomas noted that the quality of papers to the committee had significantly improved.
7.3	The Trust had now adopted the NHS Premises Assurance (PAM) Model as a tool for reporting on estates. The annual fire report would now be part of the PAM tool.
8	**Chair and Chief Executive**
8.1	Matthew Winn highlighted that the Trust had been highlighted as an organisation that could improve its performance on NHS Workforce Race Equality Standard Metric 3, the relative likelihood of BME staff entering the formal disciplinary process compared to white staff.
8.2	Matthew Winn also briefed the Board on the ongoing work to improve the board assurance framework.
8.3	Nicola Scrivings inquired whether the risks BAF would include how the risks are attached to the strategic objectives. Matthew Winn responded that all risks in Datix were tagged to a relevant organisational objective.
8.4	Nicola Scrivings inquired about the risk appetite statement and the Trust having different thresholds for risk. Taff Gidi noted that this had had not been revised since it was signed off as part of the risk management policy. Matthew Winn explained that the statement reflected that the Trust's appetite for risk was variable across different areas and might change over time and therefore will continually be assessed. The Board agreed to that the risk appetite statement should remain the same.
8.5	On risk 1349, Anne McConville challenged the statement that 'admitted without a medical need'. It was agreed that this would be revised to reflect that this referred to physiological health needs. **Action: Taff Gidi**
8.6	Anne McConville noted that the audit committee had also raised a number of points on areas where the proposed board assurance framework could be improved.
8.7	Nicola Scrivings inquired about the trend lines. Anne McConville added that the trends did not seem to show risk scores going down to show mitigations were working. Nicola Scrivings acknowledged that mitigation actions could maintain the risk score at the same level. In addition, members should be challenging the risk scores presented and mitigation actions when risks are presented at committees.
8.8	Geoff Lambert explained that the Trust had a good system for managing risk in place. This was consistently reflected in our internal audit reports. He noted that the auditors view was that the Trust had a good system in place, but there were still areas of improvement. The next step was to improve on this by improving the quality of risk reporting and ensuring good risk management practice was embedded in all areas of the Trust. The report presented by the Assistant Director of Corporate Governance to the audit committee acknowledged that the next step was to focus on training and embedding good risk management culture. It was about getting to the next level of maturity.
8.9	It was agreed that all members would review all assurance maps, not just those relevant to the committees they are members of. To update action that was already on the action log.
8.10	It was agreed that all risks needed to be reviewed and updated including anticipated completion date and closure of risks that are no longer relevant. **Action: Taff Gidi**
8.11	The Board agreed the following next steps: o To update the Board assurance framework based on comments from the Board and the Audit committee. o To ensure the assurance maps are reviewed by all members and signed off. o To further develop the board assurance framework to include links to clinical operational boards and other sources of assurance. o To ensure the changes are communicated clearly to all staff making clear what these changes mean for them in their role. o To articulate for each service a floor to board assurance map for each service. **Action: Taff Gidi**
8.12	Anne McConville noted that it would be helpful to have this in place when the Trust takes over services in the future because the maps can be used to integrate services better into our way

	of working.
8.13	Geoff Lambert highlighted that internal auditors had raised concern that implementation of internal audit actions was trending in the wrong direction. The Trust had always been good at implementing audit actions on time.
8.14	Anita Pisani responded that there were a number of actions included in the internal audit report and marked as 'no management response' received where responses had been provided to internal auditors multiple times and yet the report did not reflect this. Taff Gidi added that the inaccuracies had been flagged with internal audit and further discussions were due to take place to address this.
8.15	Mark Robbins added that the Trust had introduced a new process for monitoring implementation of audit actions which was now getting embedded. In addition, an improvement plan had also been agreed.
8.16	Richard Cooper noted that the original implementation date would have been agreed with the audit owner and therefore should be achievable. Geoff Lambert acknowledged that in some instances, there are legitimate reasons why a due date may be adjusted. What was important was to ensure agreed timelines were met or explanation offered on why the deadlines needed to be revised.
9	**Any Other Business**
9.1	To ensure the venue for Board away day is arranged being mindful of the Quality Improvement and Safety Committee meeting to be held in the morning. **Action: Taff Gidi**
10	**Questions from members of the public**
10.1	None
- Meeting closed -	

Date of next meeting: 14 March 2018,
Venue: Training Room, Suite 3, Cringleford Business Centre, Intwood Road, Cringleford, Norfolk, NR4 6AU