CHARITY NO: 1104951
COMPANY NO: 5176998

ST ANDREW'S HEALTHCARE

BOARD OF DIRECTORS
MEETING IN PUBLIC

Microsoft Teams Meeting and Meeting Room 9, William Wake House, St Andrew's Healthcare, Northampton

Thursday 25 March 2021 at 10.30 am

Present:	
Paul Burstow (PB)	Chair, Non-Executive Director
Tansi Harper (TH)	Non-Executive Director
Andrew Lee (AL)	Non-Executive Director
Elena Lokteva (EL)	Non-Executive Director
Stanton Newman (SN)	Non-Executive Director
Stuart Richmond-Watson (SRW)	Non-Executive Director
David Sallah (DS)	Non-Executive Director
Katie Fisher (KF)	Chief Executive Officer
Jess Lievesley (JL)	Deputy Chief Executive Officer
Alex Owen (AO)	Chief Finance Officer
Sanjith Kamath (SK)	Executive Medical Director
Martin Kersey (MK)	Executive HR Director

In Attendance:	
Alastair Clegg (AC)	Chief Operating Officer
John Clarke (JC)	Chief Information Officer
Duncan Long (DL)	Company Secretary
Alex Hamilton & Patient (Agenda item 2) (AH)	Clinical Director
Melanie Duncan (Minutes)	Governance Project Co-ordinator
Apologies Received:	
Paul Parsons (PP)	Non-Executive Director

Agenda Item No		Owner	Deadline
1.	**Welcome** PB (Chair) welcomed everyone to the second part of the Board of Directors (Board) meeting, which is a meeting held in public. PB introduced himself along with the Directors. He explained that this was the first live meeting held in public, and was the next part of the Charity's programme to make the Charity more visible and transparent to those that use our services. He welcomed feedback from attendees outside of the organisation.		
DIVISIONAL UPDATE			
2.	**Divisional Presentation (including Patient Voice): Blended Wards (Willow/Maple)** AC introduced Alex Hamilton, Clinical Director, and AJ, a patient from our blended ward to give a presentation. AJ wanted to outline his experience of being on a blended ward consisting of a low and medium secure setting and had prepared a small presentation on his experience. AJ highlighted that being on a blended care ward had provided both care and rehabilitation and has allowed them to progress as an individual. There is more leave, structure and independence, whilst still being supported by the team. Patients have telephone access, the opportunity to buy food, have pet therapy and internet		

	access. AJ highlighted that his future looks positive in the blended services it can reduce time in hospital and aid his recovery. PB thanked AJ for his presentation and wanted to know more about buying his own food. He asked what it meant for AJ. AJ outlined that he bought a mixture of tinned and fresh fruit that you can prepare yourself. AH clarified that one room on the ward will be changed to a kitchen to help with this. AL asked about the process of moving onto a blended ward, and wanted to know if there was any learning that could be taken on by the team. He explained that feedback to the team would help to continue to take this approach forward. AJ wanted to highlight that the independence part is important, and that nothing could be done better; he "thinks its brilliant". In particular the group work and the amount of leave. PB asked how the last 12 months with the pandemic had had an impact on him and other patients. AJ said that it had been ok. He has had a lot of leave and has had a lot of support. There has also been a lot to do. PB said that this was good to hear. KF said that it was good to see AJ and that one of the important elements of blended service was the support workers. She asked what that been like for him, and would we need to increase the amount of peer support workers. AJ replied that it was good to work with someone who has been through the same situations themselves. AJ then brought in his peer support worker into the background and wanted to say that having one helps a great deal and gives stability. MK mentioned that this was a two way thing and that the Peer Support Workers loved being on the ward too. AJ said that the Peer Support Workers break down the barriers between staff and patients. PB mentioned that the development has been a good innovation and it clearly helps. TH commented on AJ's confidence and self-esteem and asked what the next stage was, and what support would be essential for him to go back into the community. AJ was not sure, he said that at the moment he just needed the support of the staff and the sessions so that he feels more independent. He mentioned that problem solving and group work helps with anxiety. TH praised him on his confidence and said that he would be able to manage the next stage. JL thanked AJ and mentioned that there was a bit of a risk being on a new ward, but that the risk paid off, and that he hoped he was excited for the outcome. AB mentioned that it was heartening to hear a good news story and asked if there was one thing that could be done better for him or the ward. AJ replied that he thought the service was excellent and that there had not been any bad experiences as of yet. PB asked if there was anything said on the ward by other patients. AJ said that some would prefer it to be less restrictive. AH asked for clarity. AJ mentioned a kitchen for cooking; but this is now being addressed. AH said that we take on board what the patients ask, and try to find a way of doing it safely. PB replied that it was good to see that these things are being responded to. KF mentioned that the Board were keen to try and improve areas and wanted to know what AJ liked the most about being on Maple as opposed to Sunley. AJ replied that the staffing is so much better, and there is more leave along with a feeling of more independence and freedom. PB thanked AJ on behalf of the Board and wanted to take away the importance of Peer Support Workers and the fact that independence is also important. PB asked AC to thank AH for setting up the session.		

ADMINISTRATION			
3.	**Declarations Of Interest** All members of the Board present confirmed that they had no direct or indirect interest in any of the matters to be considered at the meeting that they are required by s.177 of the Companies Act 2006 and the Charity's Articles of Association to disclose.		
4.	**Minutes Of The Board Of Directors Meeting, Part Two, on 28 January 2021** The minutes captured at the meeting held on the 28 January 2021 were **AGREED** as an accurate reflection of the discussion.	**DECISION**	
5.	**Meeting Part Two - Action Log & Matters Arising** 24.09.20 01 – Board Development Plans – It was **AGREED** that this action will remain **Open** subject to the completion of the governance review. 26.11.20 01 – Board Seminars – It was **AGREED** that this action will remain **Open** subject to the completion of the governance review. 26.11.20 04 – NED Ward Visits – It was **AGREED** that this action will remain **Open** until Covid-19 restrictions are relaxed and visiting in person can recommence. 28.01.21 01 – Divisional Lessons Learned – It was **AGREED** that this action will remain **Open** as further work is required and the lessons learned are to be shared at QSC. 28.01.21 02 – Transitional Monitoring Approach (TMA) It was **AGREED** to **Close** this action. 28.01.21 03 – CQC Ratings – It was **AGREED** to **Close** this action. 28.01.21 04 - Performance Report – It was **AGREED** to **Close** this action. 28.01.21 05 - Veteran's Service – It was **AGREED** that this action will remain **Open**. 28.01.21 06 – Community Services – It was **AGREED** that this action will remain **Open** in line with Board Development plans. 28.01.21 07 – Your Voice Data – It was **AGREED** to **Close** this action. 28.01.21 08 - Interim Governance Map – It was **AGREED** to **Close** this action. 28.01.21 09 – Complaints line of sight – It was **AGREED** to **Close** this action. 28.01.21 10 – MHA Briefing Note – It was **AGREED** to **Close** this action. A number of Board members situated in William Wake House, Northampton left the meeting due to a fire alarm, however the meeting remained quorate throughout.	**DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION** **DECISION**	
CHAIR UPDATE			
6.	**Chair Update** PB began with telling the meeting that since he joined in October there was a window of opportunity for visiting a number of services at Northampton, Essex and Birmingham, and to meet colleagues in person. However that has unfortunately not been possible to continue since to the latest lockdown restrictions. However, he has been meeting virtually and has held some Q&A sessions with staff where there was lively conversation regarding setting out ambitions for the Charity going forwards. He has also met virtually with Heads		

	of Services, Heads of Nurses this week, and the Freedom To Speak Up Guardians. There have also been two half day strategy sessions in February. These sessions would feed into the Board strategy day on 26 March. One of the clear messages from these conversations, and not unsurprisingly as a result of the pandemic, is that there are a lot of tired and anxious people within the organisation, resulting in anticipation of the Board and what will be mapped in the strategy going forwards. PB further added that he has had conversations with other Non-Executive Directors, as well as attending the Court of Governors, conversations with a number of colleagues within the education and training facilities, and more detailed one to one discussions with the Governors who have responsibility for overseeing the Charity's complaints procedures. There were no further questions.		
EXECUTIVE UPDATE			
7.	**CEO's Report** The report presented by KF was taken as read. KF provided an additional update since the paper was prepared in relation to the CQC. Following an application for conditions to be removed, the CQC confirmed that all conditions for both the CAMHS and Women's Services are now removed. Furthermore we are now in the middle of the Transitional Monitoring Approach (TMA) process and we will continue to provide updates directly to the Board and via the Quality and Safety Committee. Although formal feedback and ratings are not forthcoming under the TMA approach, we are getting regular feedback that flows into our Quality Improvement Plan (QIP). KF also provided a further update on the deferred visit from HSE. HSE will now attend on 15 April on what is an 'announced' visit. This visit is timely as we will have completed our review from The British Safety Council on 14 April. TH commented that there were good early responses to ward moves, and asked what formal mechanisms were in place to ensure that they benefit our patients. AC and explained that there is a comprehensive balanced scorecard approach used in these instances. AC also explained that we regularly review every ward in any event. We look at feedback from patients, and are involving them in community meetings in the run up to the ward moves and then de-briefs afterwards. The feedback has been positive on the whole. Some lessons have already been learnt, however, a full lessons learned exercise will happen over the summer. KF asked AC to provide a little further information on the agenda for the fortnightly Quality meetings and the Metrics used at ward level. AC explained that full inspection of the ward is undertaken by the Quality team and that there are approximately 190 metrics in total. This is a Deep Dive situation and not a walk around and the looking through the RiO records produces a score and an action plan for the ward. An environmental audit along with looking at Community and staff meeting minutes to check suitability and that the ward is engaging with its staff and patients. This produces a league table, and shows ward performance. The wards have become competitive, which has continued throughout the pandemic. Meetings are designed to be supportive and to hold people to account for the action plans. These have received a positive response. There will be more performance metrics added in April, however, a consistent improvement is being shown. DS joined the meeting. DS enquired about the CQC Well-Led review and how the changes since the review have led to improvements in patient care. KF responded that we now have real-time clinical governance in place, covering all eventualities. This ability to have an early warning system in place means lessons are learned much more quickly. Good practice is shared quickly and near misses can also be shared in the same way. This is a		

	continuous quality approach, with review and improvement ongoing. Governance both clinical and corporate is still not where we want it to be or where it needs to be, however, the external review commissioned by PB will address this going forwards. EL asked regarding campaigns and social media, and whether more could be done for Sammy. KF explained that Sammy is a patient and is campaigning for deaf women's equality. We are working with our commissioning colleagues and are always working with the media in order to make sure that things like this remain in the public domain, but in a way to strengthen relationships with commissioners JL commented on the Well-Led inspection and the resultant scale of changes. We have had good feedback from the CQC and are rectifying the governance and clinical governance situation. The reality is that we are better situated, with a Board Meeting in public being a good indicator of this. The feedback from AJ is testament to this. The Report was **NOTED**		
OPERATIONS			
8.	**Performance Report** The Report presented by AC was taken as read and AC highlighted a number of key areas. The impact of Covid-19 has been significant, especially around workforce metrics and we are now looking to recover from this. We are seeing an improvement particularly to sick leave. January / February levels were high, with three significant outbreaks in Northampton. All three outbreaks are now over, with considerable support from NHSE. Improvement planning and strategy work is ongoing despite Covid-19 and what is also encouraging is that we are now piloting the new Patient Reported Experience Measures (PREMs) and will start to see the benefits of this. We did not want to wait to begin this important piece of work. SN asked about safety reporting. Whilst the last 12 months have been unusual, comparisons are not particularly helpful and it would be more insightful to look at improvements prior to Covid-19. He commented that he would like to see aspirations covering what we want to try to do. The report does not show typical levels, these would be helpful in order to show improvements. AC explained that this feeds into the benchmarking piece of work and will be involved in some of the more detailed work around safety which goes to QSC and will definitely be part of the model. AB stated that there was a report being taken to QSC. He mentioned that DS has asked what needed to go into the quality strategy. This is currently in development. Targets have also been set, particularly ambitious ones. SK updated that he had had a productive meeting with the NHS the day before, specifically around clinical benchmarking, and that we are looking at a bespoke piece of work with relevant data in order to gain meaningful conclusions. TH asked about mandatory training and whether a 90% compliance level means that 10% of the workforce is possibly unsafe? She asked if we could benchmark those HR training and development metrics as well. AC confirmed that it is already being reported on and clarified that 90% is a high target and higher than most organisations. He added that most wards were up around 95% before Covid-19 and we aim to get to 95%. It is worth bearing in mind that not all staff are patient facing and as a result fall into the 5% and it is not correct to assume untrained staff indicate unsafe work. In excess of 95% of patient facing staff will be trained. KF reaffirmed AC's point and added that we should apply benchmarking against training. This will be done in time for the next meeting. Furthermore, Maternity Leave and Long	**AC**	**27.05.21**

	Term Sick members of staff are a factor in not gaining 100%. There is only one month where the figures dipped below 90% and it is fair to point out that it is unlikely Trusts within the NHS could demonstrate this. The benchmarking comparatives will illustrate this better. SRW wished to note that good progress had been made with vaccinations, however, figures continued to look low for Birmingham. AC confirmed that there was work being undertaken in order to encourage greater take up and Tom Bingham has been running drop in sessions and covering engagement. DS asked regarding Long Term Segregation, which is the only metric reported as "not within SPC limits" and whether it would be useful to suggest that patients that are difficult can also be helped to be brought out of segregation and into a better pathway rather, than just keeping them there until discharge. SK advised that individuals are nursed in segregation away from the main ward as their interactions with other patients can be problematic. Leave is not affected generally. Each patient has a care plan for leaving the ward which is carefully managed for each individual. DS commented that segregation conjures up a different view, and that it does have an impact on patients. SK spoke around the distinction between Long Term Segregation and Seclusion. Rates of seclusion have dropped dramatically. In segregation a patient will always have a member of staff with them, and time outside in the grounds or courtyard. PB thanked SK and for clarifying the terms. The Report was **NOTED**		
9.	**Covid-19 Response Update** The Report presented by AC was taken as read and AC reported that the Covid-19 situation had improved with three positive patients at that time. Two being on Cranford Ward and one on Heygate Ward. The Heygate patient tested positive on admission, and is being nursed away from other patients. There are between 300 to 330 members of staff off sick, shielding or away with Covid-19 related issues. This level of absence is about 60% higher than in previous years, but is manageable. Non-nursing staff are being called upon to work on the wards. One benefit of this is that there is an improvement as to how the MDT rallies and supports the nursing team. It was noted that AB and AC were invited to speak at a Directors for Infection Prevention and Control session with attendance from across the NHS. Our data collation tool that was developed during Covid-19 has been requested by other NHS trusts, noting that it was good to be asked to share some best practice. SK updated on the status of vaccinations and commented that the current message is that we are moving out of the 2nd wave, however, we need to re-double our efforts and be cautious. There are some staff and patients that haven't been vaccinated. There is a 3rd wave coming, and it will be different. With regard to the vaccine programme, we set up our hub on site with the help of NGH. There have been many events organised for staff and BAME groups, in order to raise awareness and encourage the take-up of vaccines. Birmingham has shown on a national level that there is low uptake. Our efforts will continue to encourage uptake. The 26th April will see the Northampton hub up and running again for the 2nd course of vaccines. PB said that we needed to keep reminding everyone that route out of the pandemic was unlikely to be straight forward. TH asked how we were managing expectations when there would clearly be a 3rd wave, she appreciated that we were calling on non-nursing team members to help on wards, however, she wanted to know how are we were managing the risk with non-nursing staff. AC replied that these are all clinical staff who		

	are fully trained, we are not relying on people who are not trained or ward familiar. SN commented on NHS track and trace and activities off site, also that different variants of the virus may be present in Northamptonshire. EL further noted regarding the prediction of the 3rd wave and that colleagues in the NHS were already doing this and AL voiced thoughts around the Charity getting to a residual position where a small number who would not have the vaccine and then how we deal with that, especially in patient facing situations and the delivery of care. AC replied to SN and EL's questions with that as we open up to patients going off site, this will be a risk assessment approach. We also have our own Test & Trace procedure locally in addition to the NHS system. We can track any member of staff with this, along with patients. With early outbreaks we could quickly identify them and react accordingly. With regard to differing variants, we are aware of local infection rates. We also have a system and community way of working with NHSE whilst preparing for the 3rd wave. The NHS will assist in testing on wards that go into outbreak and testing is now done very quickly and makes an enormous difference. Recently, both positive cases were asymptomatic on Cranford. SK added that this approach is aligned to the NHS. Q&A sessions have been held with staff as well as using our intranet site. Drop in clinics for questions where staff can speak to a clinician have also been set up and vaccine rates have been boosted as a result. Further individuals have been identified as not vaccinated and are having one to one conversations with their line managers. It will help us to learn where we can deploy staff going forwards. We await clarity and notification on compulsory vaccination. We try and engage and push the positive benefits in the meantime. During the recruitment process, we now ask if people if they are vaccinated. This highlights the values we work and live by as a charity. KF noted the recognition we have received from NHSE/I. We are a large active provider in the Midlands and they are aware of that. Other trusts outside of the area are aware of us. The Report was **NOTED**		
10.	**Transformation Programme Progress Update** The Report presented by JL was taken as read and JL began by outlining that this report was asked for by the Board. He did not want this to be seen as a programme of ward moves. This programme was about quality and positioning the charity as system partners. TH enquired regarding the move to 10 bed wards and what difference this makes to staffing, as there is still high turnover. JL replied that we had not moved completely to this type of model yet. Blended wards are 10 bed wards, as are CAMHS. He acknowledged that there is high turnover, but that this has been a difficult year to asses properly. It was important to note however, that acuity in these wards has improved. SN asked what the quality measures and metrics looked for in this process were. JL replied that they are highlighted in performance and quality reports via QSG. Issues were not from wider performance, but they were an enabler to allow improvement. Moving some wards to lower beds has resulted in better staffing levels and it is important to note that we need to observe the situation in the round and not in isolation. SN commented that it would be helpful to see what the situation looks like before and after to the wards and to see them as milestones. PB agreed with this view. KF noted that one of the key hypothesis was that by rightsizing, we would reduce our dependence on agency workers. Whilst fully supporting before and	**JL/DL**	**29.07.21**

	after views, we would need to bear in mind that Covid-19 has sadly had an effect. KF said that she would prefer to wait until we are out of this phase before reporting. AL commented that he felt it was important to show when we have 'scored the goal'. When we move out of transformation into continual improvement, it will be important to know what that looks like. DS said that we should set out what we want to achieve, so that we can look back on it in the future, and asked if we could we show how the transformation programme could link in to Quality & Safety as it would create a stronger connection. PB noted the report's impact and said that it would be revisited. The Report is **NOTED**		
FINANCE			
11.	**NHS Improvement Annual Solvency Commitment** AO informed the Board that the Charity is required to make this self – assessment using the following statement: *"The Board of St Andrew's Healthcare formally confirm that St Andrew's Healthcare reasonably expects to have the required resources to keep our Commissioner Requested Services running over the course of the next 12 months"* AO confirmed that she was confident that we are: • Complying financially • That we have a skilled workforce in place • That we have the availability of facilities, and that • We have considered the level of current and likely future demand for Commissioner Requested Services. AO requested the Board's approval for signature and submission. The Board **AGREED.**	**DECISION**	
PEOPLE			
12.	**Patient, Carer and Employee Promise / Commitment Launch** The paper presented by MK was taken as read and MK highlighted that this work had come from discussions with patients, carers and employees, and highlights what is expected from them. Patients particularly valued respect, and when they see disrespect it concerns them. This commitment is two way, and is written in the same way. Employees have had similar input, as have carers and there is ongoing work with the People Committee. Discussions are needed on how we can measure its effectiveness and the difference it makes. DS commented that measuring the effectiveness of this will be good, and that it could be done via the People Committee. MK replied that the Employee promise will be signed off separately by the People Committee, and that the Board is asked to be held to account to fulfil the promises. PB summarised that the Board could sign off the Patient and Carer elements and that the People Committee would agree the employee element. AL noted that the term employee seems to be outdated and wondered if the term colleague would be a better option. PB agreed with AL and suggested that this be addressed at the People Committee. KF noted that CEC has received these promises and that there were a lot of lessons to be learned from this process. She confirmed that she preferred colleague. The Board **APPROVED** the paper on the understanding that the People Committee would review and approve the employee promise section.	**MK / TH** **DECISION**	**27.05.21**

GOVERNANCE AND ASSURANCE			
13.	**External Governance Review Update** PB provided a verbal update on the External Governance Review and outlined that following the feedback from the CQC Well-Led report, conversations with the Charity Commission and challenges around how governance has developed, it was agreed that an external review of governance be undertaken. PB has spent time looking at how governance has evolved and noted that there were aspects which warranted review and benchmarking to make sure that we had 'Best in Class' governance for a charity. He noted that we are not the NHS, we have a differing set of responsibilities as Trustees and our governance needs to reflect this. As a result a procurement exercise has been undertaken and we have now confirmed and appointed Ernst & Young to lead the review. This will begin soon and will take a relatively short period of time. They will report to PB and KF, and will engage with all Board colleagues and a number of other stakeholders to make sure that this exercise is worthwhile and make sure that our processes are robust. PB added that there will be requests for one to one discussions with colleagues as part of the process to help set the tone and direction The Board **NOTED** the update.		
14.	**Material Risk Register Review** The paper presented by AB was taken as read. AB highlighted that this paper demonstrated that we are in a maturing process for our Material Risk Review, especially on how we monitor them. The regular process is that this would normally go to ARC before Board, and the paper proposes a quarterly process for reporting in this way. There have been changes to the residual risk for eight risks, which have decreased and one that has increased. Deep dives of red rated risks will be undertaken by the end of this year, however we are now in a better position, but there is still work to do. AL asked if it would be more useful if a filtered view could be sent to Board rather than seeing the whole register. He also asked the question that when a CEO and Chair look at these risks, are they the things being considered. Are they the risks that are being worried about? KF replied that they were the things that are considered. For example, there is a cyber-risk which following review, we are now going to separate into two risks. This has effectively been an unknown unknown that will always be residually high. As a result we are going to separate the risk out to give each part due consideration. Covid-19 has also been high on the agenda. PB commented that there are two areas to mention. The first that we need to discern the important from urgent and as a Charity determine the order in which we do things. This will assist in the strategic change agenda and being able to determine the order of doing things will increase the bandwidth to do them well. Secondly, the impact of the pandemic at the workplace and in the lives of our colleagues together with the implications, make it a high concern. TH commented on strategic environment change and that we need to be alert around this risk as we see the fall-out from Covid-19. AB agreed that it was a fair challenge and confirmed that we look at clear evidence and we rely on the judgement of the executive who holds the risk, but, we keep challenging it. Assurances from the planned deep dives will help. SN commented on R244 and the actual risk title of Integrated Physical and Mental Healthcare. He asked if the risk on monitoring physical health is that you have done enough. He felt that there should also be a cultural element to this. SK replied that we could make the cultural element specific. The programme does have a cultural element.		

	DS asked regarding the role of CEC and expectations from Board sub-committees and wanted to know what was expected of them. He felt that clarity was needed around this. Furthermore the Covid-19 Risk indicates a reduction in risk is noted, however, the mention of a 3rd wave does not fit with this reduction in the residual rating. EL confirmed that the Risk reporting calendar is aligned going forwards and that the maturity will be addressed as part of the review by Ernst & Young. KF commented that the external review will definitely cover risk and the oversight of it. Medium term, regarding the Board Sub-Committees, it is felt that they need to test the robustness of discussion being had around the specific risks assigned. PB and KF agreed that the CEC would hold those material risks where it is unclear where they should sit. PB also noted that whilst progress had been made, that there was still work to be done. AB commented on DS' question regarding Covid-19 risk. He clarified that it shows that this is a dynamic risk register and that it reflects that we are coming out of the 2nd wave. We are in a stronger position than 6 months ago. He stated that we could review and change as we needed to. DS commented that it was difficult to see why it reduced even with wave 3 on the horizon. AC clarified that this risk was reduced to take into account measures such as testing since this was last looked at. We are not complacent, however we are confident. The Report was **NOTED**		
15.	**Sub Committee Updates** **People Committee** TH commented that there was nothing to add to the update, other than it has been helpful to develop the focussed agendas that the committee now has. The Report was **NOTED** **Quality & Safety Committee** DS gave an update on the extraordinary meeting held relating to the Hawkins Ward SI. A multi-disciplinary team conducted the investigation into Hawkins at the request of the CEC, led by a senior Forensic Psychiatrist. The report was reviewed by QSC, along with a detailed review of the action plan, with a number of additional actions added. The QSC has taken responsibility for oversight of the action plan and review the lessons learned when available. The report will be further discussed by the committee in April and a full report will be supplied to the Board following that meeting. EL commented on the excellent assurance levels from the discussion at the extraordinary QSC meeting. The Report and Update were **NOTED** with thanks to the QSC. **Pension Trustees** MK commented that there was nothing further to add. AL asked if the committee were thinking about one of the scenarios where there is a negative interest rate situation as it may happen. SRW replied that we were moving to a self-sufficient situation and de-risking rapidly. There is now a lot of investment in gilts and interest hedged. Gains have been significant recently and more hedging is now in place. The Report was **NOTED**		
ANY OTHER BUSINESS			
16.	**Questions from the Public for the Board** No questions were received for the Board.		

17.	**Any Other Urgent Business (notified to the Chair prior to the meeting)** PB wished to note that this was Paul Parsons' last meeting as a Non-Executive Director and Trustee, and wanted to extend thanks from the Board for his service to the Charity.		
18.	**Date of Next Meeting :** Board of Directors – Thursday 27 May 2021		

Approved – 27 May 2021

Paul Burstow
Chair