

## Board of Directors (in Public)

### Item 7

## minutes

### Minutes of the Board of Directors' meeting held on 30<sup>th</sup> January 2018

|   |                 |  |
|---|-----------------|--|
| <b>Present:</b>   | Neil Large      | Chairman   |
|   | Jane Tomkinson  | Chief Executive  |
|   | Nicholas Brooks | Non-Executive Director   |
|   | Julian Farmer   | Non-Executive Director   |
|   | Mark Jones      | Non-Executive Director   |
|   | Sue Pemberton   | Director of Nursing and Quality                                      |
|   | Raphael Perry   | Medical Director / Deputy Chief Executive                            |
|   | Marion Savill   | Non-Executive Director   |
|   | Darren Sinclair | Non-Executive Director   |
|   | Tony Wilding    | Director of Strategic Partnerships & Chief Operating Officer         |
|   | Claire Wilson   | Chief Finance Officer  |
| <b>In Attendance:</b>   | Mark Jackson    | Director of Research and Innovation                                  |
|   | Lucy Lavan      | Director of Corporate Affairs  |
|   | Joanne Twist    | Director of Workforce Development                                    |
| <b>Apologies for absence :</b>  | David Bricknell | Non-Executive Director/ Deputy Chair and Senior Independent Director |
|   | Lee Omar        | GT Aspiring NEDs Programme   |
| <b>Observers:<br/>Governors /<br/>Staff/ Members<br/>of the Public:</b> | Julie Hughes    | Care Quality Commission (Item 1.5)                                   |
|   | Adam Barley     | Specialist Nurse, Organ Donation (Item 1.6)                          |
|   | Tim Ridgeway    | Consultant Anaesthetist (Item 1.6)                                   |
|   | Tony Bennett    | Divisional Head of Operations – Medicine                             |

| Action

1  
Chair's  
Initials

- 1 Welcome and Opening Matters**
- 1.1 Apologies for absence**  
Apologies were received from David Bricknell and Lee Omar.
- 1.2 Declaration of interests relating to agenda items**  
The Chair asked Board members if they had any interests to declare in respect of items listed on the Board's agenda. All directors declared that they had no interests.
- 1.3 Patient Story**  
The Director of Nursing and Quality reflected on her observations of patient and family experience in the catheter labs following a recent mock CQC inspection that she and the senior nursing team had conducted. She went on to outline a number of actions that would be taken to improve the environment and facilities for patients and families.
- 1.4 Chairman's Briefing**  
The Chair thanked the executive and management teams for the actions taken to support the operational pressures facing the wider health system throughout January, including the provision of dedicated bed capacity on Mulberry Ward for respiratory patients.
- Discussions had taken place with the Chair of the Royal Liverpool and Broadgreen University Hospitals (RLBUHT) regarding the car parking pressures on the Broadgreen site and the significant impact this was having on staff, patients and visitors. A commitment had been given to review the situation.
- It was noted that RLBUHT was facing a number of challenges including completion and handover of the new hospital following the collapse of Carillion.
- The Chair reported that the Nominations and Remuneration Committee (NEDs) had recently met and would make a recommendation to the Council of Governors to re-appoint Julian Farmer for a second 3 year term.
- Councillors O'Hare and Taylor from Knowsley Council and Liverpool Council respectively had stepped down from the Council of Governors and the Trust awaited notification of the new appointed governors from these partner organisations.
- A number of governors had participated in a walkabout to Robert Owen House and Holly Suite and had taken opportunity to talk to staff and patients.
- Sir Ken Dodd had accepted an invitation to participate in the Trust's celebrations of the NHS' 70<sup>th</sup> Birthday on 5<sup>th</sup> July 2018.
- 1.5 Overview of New Care Quality Commission (CQC)**

## **Standards**

Julie Hughes, CQC Inspection Manager was welcomed to the meeting and provided a presentation to the Board on new CQC regulations and changes to the inspection regime.

The CQC Insight dashboard was being further developed as a source of key information that would support risk assessment and enable the CQC to focus on areas of highest risk. Insight would provide facts and figures relating to activity, staffing and finance and provide an intelligence overview at provider, key question and where available, at core service level. Providers would also be able to access and monitor the Insight dashboard which would highlight trends and any decline in quality indicators. The data would be used by the CQC to inform the regular relationship meetings and to highlight areas for focus at inspection.

The Insight dashboard was populated from a number of data sources and the CQC's data analysts would review and identify any areas for which the Trust might be asked to provide explanation or further information.

The CQC's new approach was based around enhanced monitoring via Insight, bi-weekly calls between the relationship team and Director of Nursing and regular engagement meetings with members of the executive team. The CQC would aim to attend at least one Board meeting each year and would organise focus groups to hear from staff and patients and may also liaise with partner organisations. This approach represented a shift away from inspection to an ongoing programme of enhanced engagement. A Well Led report would be produced annually but the CQC's initial focus was upon working with providers requiring improvement. Inspections would be conducted in future by much smaller teams. Notice would be given for Well Led reviews to enable meetings with Board members and other key personnel to be facilitated. These annual reviews would be supplemented by inspections of one or two core services which would be unannounced. Following this process the provider's overall rating would be re-assessed.

The style and content of CQC reports would in future be very different with a more concise report for the public, supplemented with a more technical appendix of evidence for use by the provider. This change followed an extensive public consultation exercise to determine what content and format was most helpful to the public.

A discussion followed the presentation and of note was the importance that the CQC would place on the Trust's participation in and leadership of research.

The Chairman thanked Julie Hughes for her attendance and advised that the Board strongly valued the CQC's feedback to support continuous improvement of services provided to patients

and families.

Julie Hughes left the meeting.

## 1.6

### **Organ Donation / Retrieval**

Tim Ridgeway and Adam Barley were welcomed to the Board and invited to present on organ donation.

It was noted that a national taskforce had been established in 2008 with the aim to improve the UK's poor record in organ donation and comparative data illustrated the UK's record compared to that of Spain where a very different ethical culture in relation to organ donation was evident.

The 14 recommendations of the 2008 taskforce were noted and the response from LHCH had included the appointment of a Clinical Lead for Organ Donation (CLOD) in 2009, the appointment of a shared Specialist Nurse for Organ Donation (SNOD), and in 2010 the establishment of an Organ Donation Committee with subsequent development and implementation of policies to support organ donation and tissue donation.

It was noted that LHCH's potential for organ donation was limited as the majority of potential donors had significant co-morbidities and often multiple organ failure, however the introduction of primary PCI and more recently the new pathway for management of out of hospital cardiac arrests had expanded the potential.

Data was presented to show increasing organ donation activity in the last 5 years along with the achievement of a 100% referral of potential deceased organ donors for the latest reporting period (April – September 2017).

It was noted that SNOD involvement with families had been proven to increase organ donation success as the SNOD was able to explain to and support the family through the full pathway of donation and demonstrate highest levels of dignity and respect for the deceased throughout the process.

The Board went on to discuss the proposed 'Opt out' organ donation system for England, which was already active in Wales. It was noted that this would entail 'soft' opt out in which families wishes would always be supported, in contrast to the 'hard' opt out process applied in Spain where families were re-approached many times until agreement was secured.

It was noted that organ donation in the UK was slowly increasing and that within the UK, the Northwest was the highest donating region. Despite this there were still 7,000 people on the transplant waiting list with a significant number dying or becoming too sick to receive a transplant whilst on the waiting list. There remained a continued problem in shortage of donors from BAME populations.

The Board considered how LHCH benchmarked with other cardiac centres and was advised that comparison was difficult due to significantly varied demographics and the fact that the majority of donation potential came from neuro centres receiving patients with isolated head injuries and minimal organ failure. For LHCH the three main indicators of success were 100% referral, 100% SNOD involvement and 100% brain stem testing, all of which had been achieved in recent months. Adam Barley went on to explain the clinical processes that followed family consent which enabled organ function after brain death to be optimised in order to maximise the chance of transplantation success.

The appointment of a CLOD in each hospital had also supported wider engagement on the subject of organ donation and was helping to secure the provision of unbiased information to families at the appropriate time.

The plans to put in place a 'soft' opt out system in England would be supported by a major public campaign which in turn would serve to further increase public awareness.

Adam Barley ended by sharing with the Board the stories of three recent LHCH donors and also read to the Board a letter written by an organ recipient to the family of the donor.

The Chair thanked Tim Ridgeway and Adam Barley for the very informative session, following which they left the meeting.

## 2

### 2.1

#### **Patient Safety and Quality**

##### **Human Factors Strategy – Progress Report**

The Director of Nursing and Quality presented the progress made in delivering the Human Factors (HF) Strategy which to date had focused on the embedding of HF education, implementation of 'HALT', standardised local safety huddle processes and learning from never events. She also provided feedback on learning from the recent National Patient Safety Conference.

A discussion followed in relation to the difficulty in identifying a tangible measure as an indicator of success of the HF strategy. It was noted that whilst harms data was actively monitored it was not possible to isolate the impact of increased human factors awareness in reducing and eliminating harm. The aim was to create a culture that enabled a consistent and strong focus on reflection and learning.

It was noted that the resource implications of the HF strategy had not been quantified but these would be considered when the strategy was refreshed in May 2018.

The Board noted the report and action plan from the 2016-18 HF Strategy.

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## **2.2 Medical Revalidation Annual Report**

The Medical Director presented the report, demonstrating that the Trust has in place a robust system for medical appraisal which is now supported by an online system enabling improved tracking of appraisal status and easier access to supporting evidence.

There were no issues with either the appraisal process for 2017 or with revalidation and no referrals had been made to the GMC.

It was noted that MIAA would be conducting a review of the process in the coming months which would provide independent assurance.

The Board noted the report and supported sign off by the Chief Executive of the Statement of Compliance

## **2.3 Learning From Deaths – Q3 Report**

The Medical Director presented the quarterly report including the mortality dashboard. All deaths at LHCH continue to be reviewed in accordance with the Mortality Review Process.

The new national guidance gave stronger emphasis to organisational learning from all deaths rather than just preventable deaths and the Trust had made good progress in implementing the new guidelines.

The Medical Director advised that there had been 6 deaths with some evidence of avoidability in the year to date and confirmed that actions identified through the mortality review process were being addressed by the appropriate Division/s.

The Board discussed the process for providing feedback to referring hospitals in instances where the mortality review process had highlighted contributing factors prior to arrival at LHCH. It was noted that whilst information was shared no direct feedback or assurance was given around learning. At the present time LHCH was able to review all in-hospital deaths but there was insufficient data available to capture learning from deaths post discharge. The value and need for regional-level coordination of themes and learning was noted.

The Board accepted the report, acknowledging good progress on meeting the new guidelines and in identifying actions from learning.

## **2.4 LHCH Monthly Staffing – November 2017 and December 2017\***

The Board received and noted the reports on staffing levels by ward and care hours per patient day for November 2017 and December 2017, and acknowledged the process of daily risk assessment to ensure safe staffing by flexing staffing levels in accordance with patient numbers and acuity.

It was noted that the detailed annual review of staffing levels would be presented to People Committee in March 2017.

The Board noted the report.

**2.5      *Deprivation of Liberty Safeguards\****

The Board noted the report.

**2.6      *Report of the Director of Infection Prevention and Control – Quarter 3\****

The Board noted the report.

**2.7      *Guardian of Safe Working – Q3 Exception Report***

The Board noted the report.

**3      *Strategy and Development***

**3.1      *Health Economy Update – NHS Cheshire and Merseyside 5YFV and CVD Pathway***

The Chief Executive advised that the CVD Programme Board now reported into the Acute Care and Sustainability Board and that a progress meeting for local leaders would take place on 7<sup>th</sup> February 2018. Early July was the target date for launch of the pre-consultation integrated business case that would set out how care would be structured in the future across Cheshire and Merseyside. The development of the business case was being supported by KPMG.

In relation to the CVD work, cases for change had been completed for 4 of the 8 workstreams and would now proceed to the Acute Sustainability Board for consideration in the overall plan. This presented an opportunity to pilot some of the recommendations, subject to securing local agreement. There remained a need to identify project management resources for the implementation phase. The Board discussed the plans, noting also the need for a region-wide assessment of bed capacity requirements.

In relation to LHCH's local planning process, no activity changes would be assumed in the short-term but the context of the Trust's annual plan would reflect ongoing systems work and the Trust's intent to continue to support this and lead in the review of CVD pathways.

A discussion followed on proposals for a single heart attack centre but as yet no clear case for change had been articulated. Discussions to clarify intent would be progressed with Andrew Gibson, Executive Chair, Cheshire and Merseyside Health and Social Care Partnership, with the aim of gaining support for focus on a single cardiology service and remove the distraction of ongoing focus on a single heart attack centre until evidence could be provided.

A key stakeholder meeting would take place on 1<sup>st</sup> February 2018 to discuss the future ACS pathway in the context that there

was neither the funding nor workforce available to manage the pathway across numerous centres.

Work to date was noted and the Board would continue to discuss the system wide plans as detail emerged.

### **3.2 Operational Planning Update**

There was no further information to update in relation to the national timetable as the 2018/19 guidance was still awaited from NHS Improvement. It was expected that the guidance would set out how the additional £1.6bn pledged to the NHS in the Chancellor's Budget would flow through the system in exchange for improvements in priority areas including cancer, mental health and waiting times. Final notification of the 2018/19 Control Totals and STF allocations was also anticipated.

It was expected that the planned submission dates for Provider draft and final plans would now slip.

Operational Planning work was progressing well with oversight from the Core Planning Group which met on a monthly basis. A weekly finance and activity meeting was established and continued to progress work on planning assumptions and trajectories.

The Business Transformation Steering Group continued to oversee the CIP planning process and good progress was being made on identification of CIP schemes for 2018/19. Divisions would present their CIP plans to the Board on 27<sup>th</sup> February 2018. The finance team was working on the Long Term Financial Model and corporate teams were preparing business plans to present to the Executive Team at the end of March 2018.

The Board noted work in progress.

## **4 Targets and Financial Performance**

### **4.1 Strategic, Financial and Operational dashboards - period ended 31<sup>st</sup> December 2017**

It was noted that The Single Oversight Framework (SOF) dashboard had been amended to reflect the addition and removal of certain targets by NHS Improvement following the publication of an updated SOF in November 2017. The changes to indicators were as summarised in Section 1 of the report.

The Director of Strategic Partnerships and Chief Operating Officer highlighted the following:

- Breach of 18 week RTT target in December 2017 (and anticipated breach in January 2018) due to high levels of acuity resulting in pressure on critical care beds and consequential high number cancellations. Plans were in place to manage the backlog of waiters and return to compliant performance at the end of February 2018.
- Breach of the diagnostic target driven by a significant increase in referrals for sleep studies and insufficient CT



capacity to meet additional provider to provider referrals. Work was underway to better understand the reasons for increased sleep study referrals and to manage the backlog of waiters, though this was expected to take a period of time; and business cases were being developed for additional CT and MR scanning capacity. It was noted that there had been a significant change in guidance on diagnostic pathways which would require increasing use of diagnostic CT in favour of angiogram. Additional MR capacity would also be needed to support the CHD service and to meet the planned new national target for definitive cancer diagnosis within 28 days.

The Board discussed the remainder of the performance report and requested inclusion of RAG rated forecast outturn data against the SOF targets going forward.

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The Chair of the Integrated Performance Committee advised that close attention had been paid to the RTT forecast position and the forecast data demonstrated a return to compliance.

It was confirmed that the Trust was on plan to achieve all key targets and service plans as at 31<sup>st</sup> March 2018.

A discussion followed in relation to the impact of breaches on the segmentation process and it was agreed that the Single Oversight Framework would be re-circulated to Board members for reference.

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It was noted that the RTT and diagnostic target breaches had been discussed with NHS Improvement at the recent Quarterly Review Meeting and in the context of wider system pressures, did not present undue concern to the regulator.

In relation to the Trust's internally set operational targets, it was noted that these were 'stretch' targets and that the RAG ratings were used to target improvement work but were not recognised for regulatory purposes.

The Chief Finance Officer referred to Appendix 5 and highlighted the overall financial performance of the Trust at Month 9.

She advised that the single biggest financial risk continued to be income from Wales in relation to recognition of HRG4+. The Welsh health system had not been funded to meet the new national tariff and the matter continued to be a subject of national debate. The risk had again be discussed at the Quarterly Review Meeting with NHS Improvement and recognition given to the fact that failure to secure a national resolution would require a reduction to the Trust's Control Total. Whilst it was likely that STF monies would still be received the issue presented a recurrent cash problem and therefore recognition of HRG4+ in the current year remained the preferred solution. Whilst the Welsh contract was underperforming slightly, Welsh

commissioners had been clear that they would only pay the prevailing tariff for which they had been funded and were unable to recognise HRG4+.

Aside from this significant financial risk, the Board noted that the financial position of the Trust remained on plan and noted the report.

## **5 Governance and Assurance**

### **5.1 Ratification of Consultant Appointments**

The Board ratified the following consultant appointments:

- Sujata Anipindi – Locum Consultant Cardiothoracic Anaesthetist
- Fahmi Faraz - Locum Consultant Cardiothoracic Anaesthetist

## **6 Board Assurance**

### **6.1 BAF Key Issues Reports and Minutes from Assurance Committee Meetings:**

#### **6.1.1 Audit Committee**

The Chair of the Audit Committee provided an update on the key issues discussed at the Audit Committee meeting held on 29<sup>th</sup> January 2018. The following points were highlighted:

- A review of progress of the clinical audit plan had indicated lung cancer survival rates as an area for further focus. This had also been noted in the recent GIRFT (Getting It Right First Time) Report, for which the Board was to receive the management response and action plan.
- The gap in assurance relating to data quality as highlighted in the Informatics Review. The Board would receive the full response and action plan.
- The internal audit plan was on track and there had been significant improvement in timely management action evidenced from MIAA's follow up review of previous recommendations. The key conclusions from the year's internal audit work would be reflected in the annual opinion provided by the Director of internal Audit
- The external audit plan was in place to deliver the statutory audit in accordance with national requirements.

#### **6.1.2 Integrated Performance Committee (IPC)**

The Chair of the Integrated Performance Committee noted that the majority of issues discussed were reflected in the finance and performance reports and that there were no new risks to bring to the Board's attention.

She noted that IPC meetings had been scheduled in accordance with last year's planning timetable and that the continued uncertainty around submission dates for the 2018/19 plan meant that there was no planned meeting of the IPC in advance of the Board's review of the annual plan.

The Board noted that the submission for 2018/19 was expected to be limited to a refresh of Year 2 of the two year plan submitted last year. The Board determined that it was adequately sighted on the internal planning process and it considered that there would be no need to convene an extraordinary meeting of the IPC to consider the plan in advance of full Board review.

### **6.1.3 Quality Committee**

The Chair of the Quality Committee highlighted the following:

- Continued focus on the documentation of responses to secure health messages relating to radiological alerts.
- Continued focus on medication errors with a 'deep dive' planned for the next meeting of the Quality Committee.

The Director of Nursing and Quality advised that the Committee was trialling a new reporting format in response to the MIAA review, and had summarised the work of the Quality and Patient & Family Experience Committee into a single summary report, avoiding the need for multiple single topic papers. There had been a mixed response following the first meeting, but the approach would be refined and evaluated further following the next meeting.

The Board noted the BAF key issues report and received the approved minutes of the meeting of the Quality Committee held on 24<sup>th</sup> October 2017.

### **6.1.4 People Committee**

The Chair of the People Committee noted that there would be a focus on the staff survey results once the detail was available.

The Board noted the BAF key issues report and received the approved minutes of the meeting of the People Committee held on 5<sup>th</sup> September 2017.

## **7 Minutes of the Board of Directors Meeting held on 28<sup>th</sup> November 2017 (in public)**

The minutes of the meeting of the Board of Directors held on 28<sup>th</sup> November 2017 (in public) were reviewed for accuracy and approved by the Board.

## **8 Action Log from Previous Meeting**

The action log was reviewed and updated as follows:

Action 1 - noted and reflected in Board business cycle – action closed;  
Action 2 – completed and closed.

## **9 Legality of Board Documentation and Decisions**

Board members confirmed that the conduct of the meeting and decisions made by the Board, to the best of their knowledge, complied with the law. Board members confirmed they were

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satisfied with the format of the meeting.

- 10**      **Date and Time of Next Meeting:**  
Tuesday 27<sup>th</sup> March 2018 at **9.00 am**.

The Board determined that in future the regular start time for Board meetings would be brought forward to 9.00am.

- 11**      The Board resolved to exclude the public at this point by reason of the private nature of business to follow.

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