

Board of Directors (in Public)

Item 9

minutes

Minutes of the Board of Directors' meeting held on 28th July 2015

Present :	David Bricknell Jane Tomkinson Lawrence Cotter Julian Farmer Debbie Herring	Non-Executive Director/ Deputy Chair and Senior Independent Director (in the Chair) Chief Executive Non-Executive Director Non-Executive Director Director of Strategy and Organisational Development Chief Finance Officer/Deputy CEO Non-Executive Director Director of Nursing and Quality Medical Director Non-Executive Director
In Attendance:	Mark Jackson Lucy Lavan Mike Shackloth	Director of Research and Informatics Associate Director of Corporate Affairs Clinical Lead – Thoracic Surgery (Item 1 only)
Apologies for absence :	Neil Large Tony Wilding	Chairman Chief Operating Officer
Observers: Governors / Staff/ Members of the Public:		

- Reflective Practice**
Mike Shackloth, Clinical Lead-Thoracic Surgery attended to present to the Board on an example of reflective practice, following the inquest into the death of a patient (BH) in January 2013.

The Board discussed the learning from this case, noting that documentation continues to be a challenge. It was noted that the

Action

Director of Nursing and Quality has scheduled an event for nursing staff in September 2015 where learning from this case will be shared, including feedback from the nurses who had been called to give evidence at Coroner's Court. The nurses' Code of Conduct will be reinforced with particular emphasis on the requirement for compliance with documentation standards.

The Medical Director advised that whilst the radiology alerting system had been remedied, there remains a need to ensure that medical staff document their responses to radiological alerts.

RAP

The Chair of the Quality Committee advised that further improvement is required on VTE assessment and prophylaxis and this will remain a focus for the Quality Committee.

LC

The Chair thanked Mike Shackloth for his presentation. Mike Shackloth left the meeting.

2 Welcome and Opening Matters

2.1 Apologies for absence

Apologies were received from Neil Large, Chairman and Tony Wilding, Chief Operating Officer. David Bricknell took the Chair in the absence of Neil Large.

The Chair welcomed Julian Farmer and Raph Perry to their first meeting of the Board of Directors.

2.2 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.

3 Patient Safety and Quality

3.1 Bi-annual review of Nursing Workforce

The Director of Nursing and Quality updated the Board on the new national emphasis upon a multi-disciplinary approach to safe staffing and the importance of time spent on direct patient care, signalling a likely change to the current approach for providing assurance on staffing levels.

The Board received and reviewed the findings of the comprehensive 6 monthly review of staffing levels which is undertaken to ensure that staffing establishments reflect activity and acuity levels. It was noted that the Quality Committee had reviewed the report and was satisfied that the methodology applied to assess safe staffing was robust.

The Board acknowledged the proactive approach taken to monitor and manage staffing on a shift by shift basis and use of the daily safety huddle to identify and address any issues.

The Board noted the report and confirmed its satisfaction with the methodologies in place that had demonstrated all areas as compliant with safe staffing levels.

A discussion followed around the significant recruitment challenges and it was noted that the availability of trained nurses nationally will not increase until 2018. Plans to incentivise local recruitment and to implement an international recruitment drive will commence in September, when the new Head of Resource takes up post.

Work is also ongoing to improve retention, informed by a robust exit interview process. Plans are being worked up through the LiA programme to improve the environment and rest facilities for staff on Cedar Ward.

The Board noted the continued reliance on bank and agency staff, referring to the amber rating for recruitment on the Trust's risk register. The Board acknowledged that the Integrated Performance Committee is monitoring the financial impact of turnover and the level of vacancies but welcomed the added focus that the new People Committee will bring to the operational and quality implications of the recruitment challenge.

The Board discussed the merits of a new team approach to care being considered by the Divisions, whereby therapists, ward clerks and other staff groups will work more closely together using a team approach to deliver more direct care to patients. The national policy drive to introduce a new Band 4 nursing role, which will incorporate medicines administration was noted. This will require a 2 year training programme (as opposed to 3 years for a registered nurse). It was noted that the Trust currently employs 15 Band 4's in clinical support roles who could be trained for this new role in 12 months. Work is underway to determine whether any of these staff wish to convert to nursing.

It was noted that the new Head of Therapies had already identified a number of areas for potential improvement and will lead on bringing physiotherapists and occupational therapists into ward Teams. There will also be a move to make nursing and therapy roles more generic in the future and a pilot study is planned on Elm Ward to test how this might work.

The Board concluded that it had received assurances that the challenges were well recognised and that innovative work is in train to build a sustainable workforce.

The Board noted the report.

3.2 LHCH Monthly Staffing – May 2015 and June 2015

The Board received the reports on staffing levels by ward for May 2015 and June 2015, noting that staffing continues to be flexed on a daily basis to manage sickness absence, vacancies and the acuity of patients.

The Board noted the report.

3.3 Patient Survey Results – Action Plan

Following a presentation to the Board in May 2015 of the National

Inpatient Survey results, the Board received a report setting out the actions and improvement work that are now in progress to further enhance the care experience for inpatients at LHCH.

A key area of focus is around discharge and it was noted that there are LiA teams looking at 'TTOs' and 'Home for Lunch'. The Care Support Team is now in place and reviewing all aspects of patient flow, including arrangements for the opening of a discharge lounge in September.

It was noted that the target assigned to the 'Home for Lunch' appeared modest (the target is to increase from 5% to 10%) and the Board questioned whether this should be more ambitious. The Director of Nursing and Quality advised that her ambition was to eventually achieve 50% but the Care Support Team had identified a number of obstacles that need time to overcome. She recommended that the target be reviewed in the Autumn after allowing time for the impact of the discharge lounge to be assessed. This was supported.

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The Board went on to explore whether the introduction of the discharge lounge might have an adverse impact on patient experience but heard that the new facility is to be located in the former Amanda Unit (once vacated in August) along with the Surgical Admissions Unit (SAU). It will not be a 'stand alone' facility and patients will be under the care and supervision of the SAU team, led by the SAU Manager until they leave the hospital. The Board requested an update on how this is working, including patient and staff feedback, in the Autumn.

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The Board noted the report and supported the action plan.

3.4 **DoLs Report***

The Board noted the report and requested that future DoLs reports include data on the number of applications actually reviewed, to enable the Board to understand the extent of delays in the external system. Whilst the number of safeguarding issues is increasing, the report provides the Board with good assurance on the process.

SP

3.5 **Director of Infection Prevention and Control – Quarterly Report Q1 2015/16**

The Board received the quarterly report, noting two patients had been identified CPE positive. The Medical Director confirmed that all patients from referring hospitals are screened prior to admission. It was noted that an initial outline strategy for the management of multi-resistant organisms has been reviewed at Quality Committee and further work is in progress to inform a prioritised business case for consideration by the Board in November, as part of the 2016/17 planning round.

RAP

The Board also noted the new risk linked with post-operative infection associated with the use of heater cooler units which can occur several years after the procedure, making the implications difficult to assess. The Medical Director advised that this is a world-wide issue and estimated that there could potentially be around 2 cases over the

next 5 years. Work is underway to identify solutions to mitigate this risk.

The Board noted the report.

3.6 Organisational Learning Policy

The Board considered the proposed Organisational Learning Policy. The Policy aims to bring together learning from a wider variety of sources than the current approach, which involves the production and dissemination of an integrated report on claims, complaints and incidents. In future, learning will be formally shared on a quarterly basis at Operational Board and cascaded to Divisions.

The Policy had been developed following the identification of a gap in controls and assurance as a result of the Board's self-assessment work on governance and the Well Led framework.

The Chief Executive requested that paragraph 3 be amended to make explicit the point that organisational learning from complaints is of significant importance to patients and families as well as for the Trust's own learning.

The Board approved the policy for immediate adoption, subject to this amendment.

MJ

The Board discussed the multiplicity of information that can inform learning including feedback from Board walkabouts. It was agreed that the learning sources set out in the policy provided a useful starting point but there is no reason why these cannot be broadened further in the future as part of the on-going review process.

4 Strategy and Development

4.1 Quality Improvement Strategy Update

The Board noted and approved the updates to the Quality Improvement Strategy which comprehensively reflected all quality targets for 2015/16.

The actions completed in response to the Francis, Keogh and Berwick (as set out at Appendix 1 to the paper) were acknowledged.

4.2 People Strategy

The Director of Strategy and OD advised that the People Strategy aimed to bring together many strands of work in progress and provide a point of focus for meeting the Trust's strategic aim to be the best NHS employer by 2019. She highlighted the four key strands underpinning the strategy and described the engagement work with staff focus groups and other stakeholders that had informed the development of the strategy. The Board noted the high level plan and milestones for the next 3 years.

The Board discussed the need for effective workforce planning to enable the new ways of working required to meet national policy and local requirements. It was noted that the Divisions had already begun this work and are giving consideration to the shape of 7 day service

provision over the next 5 years and beyond.

The establishment of the People Committee will provide improved scrutiny and assurance to the Board.

The Board approved the People Strategy.

The importance of disseminating this quickly to staff, together with a shortened leaflet version was noted.

The Chair acknowledged the work of the HR team in pulling together what was a reader-friendly and understandable document, incorporating the new Values Framework ('Our PACT').

4.3 New Models of Care – Proposed Vanguard Application

The Board discussed the opportunity to submit a vanguard bid for national funding to support the development and implementation of new models of care. The first call for bids had related to urgent care but a second tranche is seeking proposals for new models of acute care with a particular focus on collaboration. This provides an opportunity to take forward with greater pace work that the Trust is already progressing with DGH partners and /or enable the Healthy Liverpool work and the Trust's Cardiology Strategy, cementing a single pathway for cardiology in Liverpool with a view to extending to other geographical areas in the future.

The Board reflected on the recent Board session with Dr Pat Oakley on policy direction and the impetus for change and noted that the Operational Board had already considered the merits of submitting a vanguard bid and had favoured progression an application based on the development of a single cardiology pathway. This will involve collaboration with RLBUHT and Aintree to reduce variation and create a single pathway from prevention through to tertiary care. Initial discussions have already taken place with LHCH clinicians and with the local Chairs / CEOs and all had been supportive of taking forward this work, subject to wider clinical support and a full options appraisal as part of the business case development.

The timeframe requires the submission of an initial application by 31st July 2015. Shortlisted bids will then be required to present to a national panel in September, with a decision soon after.

The Board discussed the benefits of the vanguard process to drive this forward and also the timing, in recognition that this will be a significant piece of work, requiring the release of dedicated time from key individuals to ensure the focus and pace required.

The Board noted that this work is integral to the Trust's Cardiology Strategy and the vanguard process could provide the traction needed for driving the work as well as enabling learning and support from others and opportunity to consider the full range of options. The recent stakeholder feedback exercise had highlighted that health economy partners are looking to LHCH to lead this work and gather pace in defining the clinical pathway for Cardiology. The opportunity

will also enable the Trust to seek support financially to drive forward work needed to fit with the changing landscape and policy direction both locally and nationally.

The Board supported the submission of an application, noting the requirement for full engagement with staff around both stakeholder feedback, impetus for new models of care and the strategic options for delivery of services in the future.

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4.4 Business Case – Outpatient Department

The Board received the business case. It was noted that the outpatient improvement work had already been prioritised within the Trust's capital programme for 2015/16 but that the cost of the scheme had increased by approximately £200k over the initial estimate.

The Board accepted the need for additional capacity in outpatients and the need to improve patient flow and the environment and thus deliver a better patient experience.

The Board discussed the project management arrangements and sought assurance that disruption to patient services will be minimised during the building work. It was noted that the Trust had sufficient expertise to ensure delivery of the capital programme and that management of this scheme would pose no greater challenge than any other capital project. Arrangements have been made to ensure a physical presence by the Divisional Head of Nursing and the Patient Services Team who will support patients, visitors and staff throughout the works and address any issues affecting patient experience at this time.

The area requiring most management attention will be facilitation of the changes to working practice including introduction of self-serve check in and other new ways of working.

The Board approved the revised sum of £656k to invest in improved Outpatient facilities as set out in the business case.

4.5 Chief Executive's Report

The Chief Executive presented the report, noting the following updates:

- Listening into Action - conclusion of the first round of Big Conversations, identification of common themes which have informed the selection of the first tranche of 20 week work programmes and a series of 'quick wins';
- Strategic Partnership Update – opportunity for vanguard bid and plans for responding to stakeholder feedback;
- Healthy Liverpool Programme – gathering of pace and publication of a joint statement on the shared vision, providing impetus to discuss strategic options;
- Deanery visit – this had been successful and the Trust will respond to recommendations by 22nd August 2015, ahead of

the formal follow up visit in October;

- Response to Francis Review into Whistleblowing – assignment of the role of ‘Freedom to Speak Up Guardian’ to Lucy Lavan, Associate Director of Corporate Affairs;
- Inquest held on 11th June 2015 – narrative conclusion and learning identified as described in Mike Shackloth’s earlier presentation;
- Regulatory Updates – planned changes to Monitor Risk Assessment Framework and changes to RTT standards
- Analysis of top risks as set out in the report.

The Board requested an update on Warrington and Halton’s intent to establish a Primary PCI service and heard that there is an informal understanding that the establishment of a new service in Warrington is not best use of resources at the present time.

The development of LHCH’s role as network leader for cardiology in Liverpool was discussed and the Board asked whether this focus would impact on the Trust’s capacity to work with other partners including Southport and Wirral. It was confirmed that there will continue to be two distinct strands to the Trust strategy – network leader locally and provision of support and joint working with DGH partners outside of Liverpool.

It was noted that the gaps around consultant job planning had been flagged on the risk register and the Board noted that good progress is being made with considerable focus and attention from the Medical Director.

The Board noted the report.

5 Targets and Financial Performance

5.1 Board Dashboard – Strategic Indicators and Operational Performance

The Board reviewed the strategic and operational dashboards and discussed adverse variances in operational performance in relation to:

- Agency and bank expenditure
- Mixed sex accommodation breaches and the positive impact of patient flow work;
- 26 week RTT target for Wales;
- Cancelled operations, including 2 breaches of the 28 day target (in April 2015);
- Staff appraisals and the planned delay pending launch of new appraisal system and Values Framework in July 2015; and
- Staff turnover.

It was noted that sickness absence in June was 3.13% with the trend continuing to improve.

The low response rate for the staff FFT was noted and it was suggested that an improvement target be set to enable leaders to focus on encouraging their teams to respond.

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The Chair of the Integrated Performance Committee briefed the Board on the Committee's focus on cancelled operations and advised that there had been a continued deterioration at a time when surgical activity had been below plan. It was acknowledged that the proportion of emergency admissions, compared to elective is continuing to grow. The primary reasons for cancellation in the first Quarter were elective list overruns, displacement for emergency cases; and critical care capacity. The recruitment challenge had hindered the Trust's ability to open the additional 4 HDU beds but in time this will alleviate pressures for POCCU.

The Board acknowledged the impact of cancellations on patients and wider impact on their family lives, highlighting the importance of work to improve patient flow.

It was noted that the Trust does not have the capacity to create dedicated facilities to meet emergency demand and will continue with the option of offering treatment at Stoke as an alternative.

The IPC has requested 'deep dives' into cancelled operations and CIP delivery and will be hearing directly from Divisional teams on these issues in October 2015.

The Board also expressed concern about the lengthy waiting times for Welsh patients. Whilst clinical priority continues to be considered, the need for further work with Welsh commissioners to improve this situation was highlighted.

The Board noted the report.

5.2 Update on RTT Action Plan and Forward Trajectory

The Chief Finance Officer delivered the report in the absence of the Chief Operating Officer noting progress with the action plan to manage activity and backlog in order to return to compliance with the 18 week RTT target by July 2015; and also updated the Board on national changes to the RTT operational standards and reporting arrangements.

It was noted that the admitted and non-admitted operational standards had been abolished in favour of the incomplete standard which will now be the sole measure of RTT performance.

The Board noted the backlog position in both Surgery and Cardiology for each month in Quarter 1 and noted that the Trust had achieved compliance (in aggregate) with the incomplete pathway standard by a small margin. The key risks associated with maintaining compliance going forward were discussed along with the need for greater focus on the forward trajectory.

The Chair of the Integrated Performance Committee commended the work undertaken to achieve compliance at Q1 and advised that the change to the targets had affected the way in which patients had been scheduled for treatment in Q2. This factor along with the continuation of high emergency demand posed further risks for compliance at Q2 and this had been flagged on the risk register (Risk Score 12).

The Board noted the report.

5.3 7 Day Working – Gap Analysis

The Board received the paper, noting that the gap analysis reflected the responses to a standard reporting template that the Trust is required to submit. There is a need for wider consideration as to what a future 7 day service should look like at LHCH.

The Board discussed the ongoing national issues relating to pay rates for doctors in training and changes to the consultant contract and how these factors might affect plans for 7 day services.

It was agreed that 7 day service provision will be a focus for the 2016/17 planning round.

The Board noted the report.

5.4 Finance Report for period ended 30.6.15

The Board received the finance report for Month 3.

Key highlights include:

- an overall continuity of services risk rating of 3;
- capital expenditure at £1.1m in line with the planned profile at the end of June 2015 (£1.3m);
- cash balances at £7.2 million; below the planned cash balance of £8.0m;
- a normalised net deficit of £463k against a planned deficit of £350k;
- total income below plan by £487k;
- CIP achieved at £1.0m (planned CIP £1.1m).

It was noted that the report had been reviewed in detail at July's Integrated Performance Committee meeting and that the Committee had requested sight of SLR data. The Chief Finance Officer advised that an SLR report had been prepared and will be circulated to Directors. The Board requested that an overview of improvements in productivity seen from review of SLR data and complemented by a review of comparative NCBC data be brought to the Board in the Autumn.

The Chair of the IPC confirmed that CIP delivery continued to be a significant risk with £1m schemes rated amber and a further £1m unidentified. It was noted that the newly established CIP Steering Group chaired by the CEO would bring significant focus to the CIP programme. In addition, the new Divisional Leadership teams had

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already demonstrated a strong grip on operational performance and a rigorous approach to financial management.

The Board noted the continued reliance on bank and agency staff which is negating any positive impact of CIP delivery. The Board heard that there are a number of anomalies in pay rates making it unfavourable for Trust staff to work overtime and thus increasing the requirement for agency workers. The Chief Executive advised that there will be some rapid decisions and change aimed to bring down the total pay bill, ensuring equity and transparency and improving staff satisfaction. Other changes which require a more formal negotiation process will take longer but will be in place by the end of the financial year. Updates on action and timeframes will be provided to the Non-Executive Directors via the CEO's 'Friday Briefing' e mail.

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The shortfall on planned activity and income is largely a result of the slow start to the TAVI work in 2015/16 and it was noted that the new delivery model for TAVI will commence in October, freeing up surgical capacity. Private patient activity is also below plan. The Board highlighted for the potential of the summer holiday period to impact further on activity and income levels in Q2 and consequential need for strong operational grip.

The Board noted the report.

5.5 Quarter 1 Monitor Return and Board Declarations

The Board reviewed the narrative report that supported the Q1 monitoring return and requested that this be updated to include commentary signalling the potential risks surrounding RTT compliance going forward given the continuation of increased emergency demand.

Subject to this amendment, the Board supported the submission to Monitor of the narrative to support the Q1 return reflecting a green governance rating and overall Continuity of Services Rating 3.

The Board declarations were confirmed as follows:

- For finance, the Board anticipates that the Trust will continue to maintain a CoSR rating of at least 3 over the next 12 months;
- For governance, that the Board is satisfied that plans in place are sufficient to ensure : ongoing compliance with all existing targets (after the application of thresholds) as set out in Appendix A of the Risk Assessment Framework; and a commitment to comply with all known targets going forward;
- Otherwise that the Board confirms there are no matters arising in the quarter requiring an exception report to Monitor (per the Risk Assessment Framework , Diagram 6) which have not already been reported.

The Board approved the Q1 return and Board declarations.

5.6 Reference Cost Submission

The Board received a report demonstrating that the Trust had

completed the reference cost submission in accordance with reference cost guidance and approved the 2014/15 reference cost submission.

It was noted that the IPC had reviewed the submission in detail and that the draft CHKS external Costing and Coding audit had been brought to its attention; whilst coding had been rated 'green', costing had been rated 'red'. The red rating is materially driven by the incorrect treatment of Ivacaftor in tablet form for 2013/14 (it was noted that the guidance for 2014/15 had been altered to expressly guide treatment in 2014/15 reference costs); alongside an inability to formally evidence senior review and sign off. The Board was informed that both issues had been dealt with in the 2014/15 Reference Cost submission. An action plan and response will be developed and brought to the next meeting of IPC.

6 Governance and Assurance

6.1 Governance Review

The Associate Director of Corporate Affairs presented a paper summarising outputs from the governance review processes that had led to a number of recommendations for the Board's consideration. It was noted that the Board had been fully engaged in reviewing the governance arrangements through completion of a Board evaluation exercise in February 2015, involvement in a number of MIAA reviews, including observation and feedback on the IPC and Quality Committee and discussion on the well Led Framework and Committee effectiveness at the Board Development Day in June 2015.

The Board supported the proposed changes to the Committee structure which involved the introduction of a new 'People Committee'. This will operate initially for a 12 month period, addressing the assurance gaps identified around the workforce agenda. A review of the effectiveness of this Committee and the need for its continuation will be considered in 12 months' time.

Other changes related to the sub structure of the Operational Board. An assurance mapping exercise undertaken by the executive team supported a proposal to disband the majority of the executive-led functional groups in favour of transacting the vast majority of operational business through the Divisions.

The Terms of Reference and business cycles for the Quality Committee and IPC have been streamlined to eliminate duplication as a result of the People Committee being the new focus for workforce assurance. The Quality Committee's revised business cycle also addresses any gaps arising from the cessation of the Clinical Quality and Patient Experience Group in respect of Trust-wide issues that are not assigned to Divisions.

The review recommended continuation of the Risk Management and Corporate Governance Committee, which will report directly to Operational Board but will continue to provide assurance to IPC on health and safety, emergency preparedness and business continuity

arrangements. This Committee will also provide a report to the Audit Committee twice yearly on the effectiveness of the risk management arrangements, through measurement of the KPIs set out in the new Risk Management Strategy.

A new CIP Steering Group will also report to Operational Board along with an Operational Planning Group which will meet on a 'task and finish' basis to support the annual planning round.

The Board approved the new Committee structure as set out at Appendix 2 of the report.

The revisions to the Terms of Reference for the Quality Committee were reviewed and approved, subject to amendment of the quoracy which should revert to read 'chair or vice chair plus one other member'.

The revisions to the Terms of Reference for the IPC were reviewed and approved, subject to amendment of the membership section and removal of the requirement for the Director of Strategy and OD to be designated a regular attendee. This reflected the reassignment of much of the assurance work on workforce to the new People Committee.

The Terms of Reference for the new People Committee were reviewed and approved.

The Board approved the changes to the Operational Board's Terms of Reference; primarily these concerned new membership and strengthening of Divisional responsibilities for performance management, enforced by the revisions to the reporting structure and sub committees.

The Board noted and approved the changes to the Terms of Reference for the Nominations and Remuneration (Executive) Committee (Appendix 7).

The Board reviewed section 5 of the report, noting the actions that had been addressed in relation to the Board's earlier review of Committee effectiveness. These included:

- A formal note of the Board's consideration of and acceptance of the current scheduling of IPC, which due to timing, prevents the production of a written BAF key issues report from this Committee. The Board confirmed that it was content with this arrangement, noting that it has direct assurance through receipt of the comprehensive finance and performance reports and benefits from verbal feedback on the scrutiny of data prior to Board from the Chair and members of IPC.
- The Board accepted the recommendation from MIAA that the Trust Chairman should not be a formal member of the IPC (or any Board assurance Committee) in order to retain his independence and ensure appropriate and effective challenge at the Board itself. As a result the roles and

responsibilities of the Non-Executive Directors have been reviewed, with 3 NEDs designated members of each of the three Assurance Committees (Quality, IPC and People).

- Action to improve the quality of minutes at Committee level – the Committee protocol, identifying roles and responsibilities of the Chair, Executive Lead and Committee Secretary has been reaffirmed; and two Committee secretaries have attended minute skills training with NHS Providers and shared their learning with the full team. Rollout of further training and monitoring of standards will be incorporated into the objectives of the Executive Office Manager.

Finally, the Board received and approved the management response and action plan (Appendix 8) that had been compiled in response to MIAA's review of the sufficiency and appropriateness of evidence underpinning the 2015 Corporate Governance Statement (MIAA's report was reviewed by the Board in May 2015).

The Board approved all recommendations.

6.2 Review of Governance Manual

The Board received and accepted the recommendation from the Audit Committee and approved the updated Governance Manual, for adoption, as presented, subject to:

- i) Incorporation of a new 'Section 3' comprising the new governance structure and updated Committee Terms of Reference, as approved by the Board (Item 6.1); and
- ii) Amendment of the Scheme of Reservation and Delegation to reflect the approved changes to Committee Terms of Reference (item 6.1)

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The updated manual will then be uploaded onto the intranet and a communication sent to notify staff.

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6.3 Ratification of Use of the Trust Seal

The Board received the paper and ratified application of the Trust's seal to documentation relating to the construction of the new cystic fibrosis ward.

6.4 Major Incident Plan

The Board received and approved the Major Incident Plan which had been updated to reflect latest national guidance; and noted that the detail had been reviewed at IPC the previous day.

Plans for testing, training staff and a multi-site simulation exercise in the Autumn were noted.

6.5 Risk Management Action Plan

The Board noted progress to date in delivery of the risk management action plan and acknowledged a much clearer line of sight on risk from Ward to Board, supported by regular review of the risk register at Operational Board, demonstrating that risk process is now more closely aligned to business management.

It was noted that the recent round of ECS reviews on wards had provided assurance that frontline staff are able to articulate the risks in their areas.

A new electronic risk management system (Datix) has been commissioned but will not be available until the end of the year; in the meantime, staff are able to access risk management reports on desktops via the Athena portal.

The Board noted the report.

6.6 Data Quality Strategy

The Director of Research and Informatics advised that the proposed Data Quality Strategy will address the gap identified from the Well Led Framework review and went on to explain the methodology used to assess and report on the quality of data, framed around 6 distinct dimensions.

The Board reviewed work in progress in respect of the data quality assessments applied to the Board's operational KPIs, each dimension having been rated 'red' or 'green'. Improvement work will focus on moving the red rated indicators to green but it was accepted that there will always remain some red rated dimensions as a result of time lags for data generated from external systems and in some cases where the investment required to improve would outweigh the benefit.

Work to date had focused upon the Board metrics but the aim is to rollout the methodology to incorporate a wider range of metrics over time.

The Board discussed the use of data quality ratings to inform Board and Committee papers and noted that there will no longer be a data quality rating assigned to every report; the rating will be applicable only when the narrative paper incorporates the indicators that have been data quality assessed. It is estimated that full rollout of the methodology will take at least 2 years with potential to extend to wider reaching work such as clinical audit. It was recognised that the methodology is onerous but will provide much stronger assurance on the validity of data used for performance management and business decisions. The Informatics team will undertake the data quality assessments and assign the red / green ratings to each dimension based upon the clear criteria set out in the strategy document. The process will be validated through inclusion of an annual review by MIAA to be incorporated within the annual internal audit programme.

The Board approved the Data Quality Strategy for implementation.

6.7 External Review of EPR – Management Response and Action Plan

The Board noted the report summarising the key findings of the ATOS review. It was noted that the report had erroneously been dated March 2014 and this should in fact read 'March 2015'.

The Chief Finance Officer advised that he is in the process of compiling the management response and action plan and that this will be circulated to members of the Board by the end of July 2015.

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6.8 Ratification of Consultant Appointments

The Board noted the report and ratified the appointments of Drs Quarterman, Shaban, Hammond and Aggerwal. Dr Aggerwal's appointment will support the backfill requirements to release time for Dr Perry and Dr Morris to focus on their new leadership roles.

The Board members involved in the appointment panels noted that the calibre demonstrated by all four appointees at interview was exceptional.

6.9 Regulatory Updates : CQC Intelligent Monitoring Report*

The Board received the report, noting out of 53 indicators, emergency admissions continued to be flagged as a risk and whistleblowing alerts, an elevated risk; placing the Trust at Priority Band 5.

7 Board Assurance

7.1 Quarterly Review of Board Assurance Framework

The Board received the paper and noted the progress made towards closing the gaps in controls and assurances that had been identified at the start of the financial year.

The Board considered the risk ratings applied to two principal risks as follows:

- Risk 3 – a reduced risk score (green) in recognition of achievement of compliance with the RTT standard (incomplete pathway) at Quarter 1. The Board recognised that risks relating to compliance in Quarter 2 were scored 12 on the Trust risk register and continued to demand focused attention. However, the BAF risk rating was appropriate as it reflected compliance across the full range of regulatory requirements. The Chair of the IPC advised that there is a gap in assurance relating to the impact of the new financial metrics that are likely to be incorporated into a new Risk Assessment Framework from Monitor. It was acknowledged that whilst the new metrics had not yet officially come into force, the BAF should be updated to reflect this risk, pending a full impact analysis. This was supported.
- Risk 6 – the Board confirmed that this risk should remain rated red in recognition of the continued risk associated with CIP delivery.

The Board confirmed inclusion of new controls in relation to the Care Support Team, CIP Steering Group and appointment of a new Clinical Lead for Medical Education.

Additional risks / gaps relating to the challenges around involving nurses in mortality reviews, work needed to mitigate further mixed sex breaches and the need to improve processes to support consultant job planning were supported.

The Board approved all recommended updates to the BAF, with the addition of reference to the impact of new financial metrics, as described above.

The Board agreed that in future it will take assurance from approved Committee minutes only and that the practice of receiving unapproved minutes at the Board shall cease.

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7.2 BAF Key Issues Reports and Minutes from Assurance Committee Meetings:

7.2.1 Quality Committee BAF Key Issues Report

The Chair of the Quality Committee presented the report, highlighting continued focus on compliance with the sepsis bundle and work to improve the management of VTE.

He updated the Board on steps taken to address outlying performance noting that the consultant concerned had for the moment, voluntarily withdrawn from combined CABG and aortic valve procedures; and that the practitioner's results for the stand alone procedures were not in question and remained strong. The ongoing processes for mentoring, support and monitoring will continue in accordance with the Trust's policy.

The Board noted the report.

7.2.2 Integrated Performance Committee BAF Key Issues Report (Oral)

The Chair of IPC advised that all key issues had been discussed previously within the meeting and that the work of the Committee had supported the Board's decisions in relation to the Q1 monitoring returns and Board declarations.

7.2.3 Audit Committee BAF Key Issues Report

The Chair of the Audit Committee presented the report and noted the work in progress to evaluate the performance of the external auditor which will inform a recommendation to Governors on re-appointment and / or the timing of a future market testing exercise.

He went on to highlight the limited assurance report from MIAA in respect of consultant job planning and his request that the Medical Director and Director of Strategy and OD attend the next Audit Committee meeting to discuss the management response and progress with the action plan.

RAP/DH

The Board noted the report.

7.2.4 Charitable Funds Committee BAF Key Issues Report

The Chair of the Charitable Funds Committee presented the report and updated the Board on work in progress too develop a case for a

major fundraising appeal.

The Board noted the report.

Liverpool Heart and Chest Hospital Charity Annual Report and Accounts 2014/15

The Board approved the 2014/15 Annual Report and Accounts for Liverpool Heart and Chest Hospital Charity.

7.3 Operational Board

Summary Report for meetings held on 19th June 2015 and 23-24 July 2015*

The Board noted the report.

8 Chairman's Briefing

The Chair had no items to report.

9 Minutes of the Board of Directors Meeting held on 26th May 2015 (in public)

The minutes of the meeting of the Board of Directors held on 26th May 2015 (in public) were reviewed for accuracy and approved by the Board.

10 Action Log from Previous Meeting

The action log was reviewed and updated as follows:

- Actions 1, 2, 3, 5, 8 -10, 12, 16 and 19 - completed and closed
- Action 4 – the Chair of the Quality Committee advised that further detail had been requested to support the QIAs of two of the major workforce schemes; and that there remain a number of schemes that require full QIAs; therefore this action is partially completed.
- Action 6 – the timeframe for this action is now October 2015, when Divisional teams will attend IPC to enable a deep dive of CIPs
- Actions 11 – action closed due to unavailability of information.
- Action 13 – to be deleted as this assurance work will now be picked up by the People Committee
- Action 14 – timeframe reviewed – Board to consider in Autumn 2015
- Action 18 – timeframe reviewed – Divisional planning work to commence and service strategies to be presented to the Board on 16.2.16 by Divisional Teams and Clinical Leads
- Action 20 – for review November 2015

All actions not listed above will carry forward per designated review dates.

11 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 satisfied with the format of the meeting.

- 12** **Date and Time of Next Meeting:**
Tuesday 20th October 2015 at 9.30am
- 13** The Board resolved to exclude the public at this point by reason of the private nature of business to follow.

DRAFT