

**Board of Directors (in Public)**  
**Item 1.3**

**minutes**

**Minutes of the Meeting of the Board of Directors**  
**held on 9<sup>th</sup> April 2024**

<b>Present:</b>	Val Davies	Chair
	Liz Bishop	Chief Executive
	Margaret Carney	Non-Executive Director
	Joan Mathews	Director of Nursing, Quality & Safety
	Karan Wheatcroft	Director of Risk & Improvement
	James Thomson	Chief Finance Officer
	Nick Brooks	Non-Executive Director
	Manoj Kuduvalli	Medical Director
	Julian Farmer	Non-Executive Director
	Bob Burgoyne	Non-Executive Director
	Tom Pharaoh	Director of Strategy
	Kate Warriner	Chief Digital & Information Officer
	Jonathan Mathews	Chief Operating Officer
	John Doyle	Non-Executive Director
<b>In Attendance:</b>	Ruth Gaunt	Executive Office Manager & Governance Lead
	Anne Marie Davies	Associate Non-Executive Director
	Rachael McDonald	Deputy Director HR and L&D (Deputising for the Chief People Officer)
<b>Observers- Governors/ Staff/ Members of the Public:</b>	Stephen Storey	Public Governor - Cheshire
	Anuj Sharma	Ergea group, Account Director of Transformation Services
	Keith Wilson	Governor
	David Bromilow	Governor
<b>Apologies for absence:</b>	Jane Royds	Chief People Officer
	Jay Wright	Director of Research
	Claudette Elliot	Non-Executive Director
	Julian Farmer	Non-Executive Director

**Action**

- Welcome and Opening Matters**  
The Chair opened the meeting and introduced the attendees. The Board also made introductions.

The Chair confirmed that Karan Wheatcroft, Director of Risk and Improvement will leave the Trust in June 2024 and will be replaced by Ben Vinter as Director of Governance and Risk. Claudette Elliot and John Doyle have recently joined the Board of Directors as Non-Executive Directors. Following several changes, the Board have a full membership with plans for Board development for the year ahead.

**1.1 Apologies for Absence**

Apologies for absence were noted as above.

**1.2 Declaration of interests relating to agenda items**

All meeting participants were asked to declare any interests in respect of items listed on the agenda.

Participants confirmed that they had no interests to declare.

**1.3 Minutes of the Board of Directors Meeting held (in public) on 31<sup>st</sup> January 2024 – for approval**

The minutes of the meeting of the Board of Directors held on the 31<sup>st</sup> January 2024 (in public) were reviewed for accuracy and **approved** by the Board of Directors with the following amendment:

Item 2.3, last paragraph to be amended to 'NB further questioned if surgical site infections data can be displayed on a dashboard'.

**1.4 Action Log (Public) from Previous Meeting**

The action log was reviewed, and the following actions were noted as complete and removed from the action log:

- An update against the Fuller recommendations. JoanM noted that an email has been received from the Clinical Services manager at LUHFT confirming compliance with recommendations and full report in progress, final report expected.
- Digital and nursing to work together regarding end of life dashboard and support with streamlining forms. JoanM confirmed an existing End of Life dashboard is being developed in line with Trust dashboards, good progress made.
- Paper had been shared setting out executive and leadership changes and portfolios at the Board Strategy day, 6th March 2024.

The following action remains open with an update provided:

- Collate Infection Prevention data from other Trusts for benchmarking purposes. Benchmarking work is complex but ongoing. Will remain on action log until reported to Board. MK updated the Board with the context that it has proven difficult to obtain benchmarking data. The team will persist in exploring alternative benchmarking platforms.

The remaining actions were in progress or due later in the year.

**1.5 MET Team / Deterioration of patients Presentation**

Kirsty Dudley, Divisional Director of Nursing for Clinical Services, previous Critical Care Lead nurse, provided an overview of MET (Medical Emergency Team) / Deterioration of patients.

A review had taken place a number of years ago following an increase in numbers of deteriorating patients after 8pm. Out of hours was noted from incident reporting and outreach data with several potential causes. Upon review, several workstreams were established including data collection, handover process, staffing, training and education, escalation of poorly patients, MET call, hospital at night and medical staff review.

Actions were taken and improvements made, including full 24/7 Outreach cover; MDT handover for the out of hours team in the hub; electronic referral for at risk / deteriorating patients; ILS Resuscitation status for Band 5 RGN; implementation of MET Team; awareness and training for MEWS and escalation to MET Team; streamlining of all Cardiac Arrest Trolleys; portable AED in non-clinical areas across the site collaborative working with Broadgreen and Critical Care in offering of Level 2/3 beds for their deteriorating patients.

Future plans include collaborative working across the Broadgreen site and critical care offering of Level 2/3 beds for deteriorating patients. Call 4 Concern (C4C) pilot to start in May 2024, along with the review and implementation of Marthas Rule.

The Board extended their congratulations the team in what instinctively feels safer overnight. The availability of data regarding outcomes was inquired. It was confirmed that the team could work on this data going forward, readmissions are currently reviewed in isolation. It was suggested that other areas could learn from the benefits of the 24 hour MET team and data would demonstrate this.

Joan Mathews explained that the MET team has been involved with delirious patients and stroke patients where improved outcomes have been noted.

It was questioned whether the MET call would bypass the hospital at night team or doctor on call. It was confirmed that should a patient trigger a MEWS on the ward, this would go to the Outreach team initially who would escalate appropriately. The hospital at night team consist of the Tier 1 for medicine and surgery, senior surgery registrar, coordinator, outreach nurse, ODP, critical care nurse in charge, ANP.

It was questioned whether there may have been missed opportunities in order to make the improvements sooner and whether staff had opportunities to highlight this with confidence. It was confirmed that the escalation process for MEWS is embedded across all clinical areas and has worked well, not all Hospitals have a 24 hour MET team. LHCH are in a privileged position to be able to provide this.

- 1.6** The Board thanked the team and **noted** the presentation.

### **Patient Story**

The positive patient video story was shared. The patient had received several cardioversions, ablations and medicines. The patient highlighted the

excellent quality of care received and hopes to be discharged imminently. The patient believed that LHCH stands out as a gem in the NHS. He was treated with dignity, well looked after, everything explained fully. Patient and family noted their gratitude for care received at LHCH and felt no improvements could be made.

The patient's account was recognised as a significant commendation for the Trust and the manner in which the staff care for patients.

## 1.7

### Staff Story

Deputy Director of HR and L&D introduced the LHCH staff video story. Ellie Modiak outlined her positive experience during the apprenticeship scheme which was carried out in the estates department. A great example of increased diversity in the team and support received from the Trust and college. Ellie is looking forward to continuing her journey and building on professional development with support from the L&D team.

The importance of the Learning and Development (L&D) strategy was noted, particularly 'growing your own'. There are currently 21 apprenticeships across 34 providers. The apprenticeships first model should be considered when reviewing structures and vacancies.

MC noted that Ellie's story had been shared at the People Committee, and although apprenticeship updates were not initially reported, the work plan has since been adjusted to emphasise their importance.

It was questioned whether the scheme is diverse, overlined with data from Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES). The group acknowledged improvements in WRES and WDES but further efforts are required. The L&D strategy links closely with the Equality, Diversity, Inclusion, Belonging (EDIB) strategy. To be included in the dashboard presented at the People Committee.

RMc

The staff story programme has been agreed in order to showcase staff groups that are less visible, highlighting challenges faced and providing a triangulation within the Trust.

The Board **noted** the patient story.

## 1.8

### Chair's Briefing

The Chair thanked all involved in producing great staff survey results and creating a culture where those results continue to improve year on year.

The Chair congratulated the Chief Digital & Information Officer and team for being the first in Europe to achieve Healthcare Information and Management Systems Society (HIMSS) level 7.

Following discussion, the memorandum of understanding between LHCH and Manx Care has been finalised and signed. Parties are committed to providing the best possible care for the residents of Liverpool, the Isle of Man (IoM), and the wider North West and North Wales region. To this end, parties will work together to determine the optimum approach to providing high quality health care that is equitable and sustainable (clinically, operationally, and financially).

The Board **noted** the update.

## 1.9

### **CEO's Report**

The CEO report provided an update on a range of issues. The report was taken as read and the following points were highlighted.

The current emphasis at system level is on urgent and emergency care routes, considering the strain the system is experiencing.

Executive Director annual appraisals had started, including use of the NHS Leadership Competency Framework self-assessment which will be logged as part of the overall appraisal for 2023/24. There will be a strong focus on objective setting.

A CQC engagement meeting had taken place. It was highlighted that when an organisation has significant changes in leadership, there are often flurries of direct concerns being raised with the CQC, however this had not been the case for LHCH.

The ICB had also undertaken a quality visit at LHCH, for which positive feedback was received and the formal report awaited.

The Board **noted** the update.

## 2

### **Safety and Quality**

## 2.1

#### **Excellent, Efficient, Compassionate Safe Assessments**

The Director of Nursing, Quality & Safety presented the EECS assessments report, providing assurance to the Board of Directors on the standards of care and practice across clinical areas and departments. All ward areas except one have achieved gold status, other non-clinical areas are either already gold or green and working towards gold. Plans are being developed to commence the assessment in 2024/25 aligned to the new CQC single assessment framework.

Acute Cardiac Unit (ACU) will be reviewed again in June 2024 following the initial assessment, with a focus on compliance with uniform policy, maintenance of equipment, and visible leadership. It is expected that ward managers visit each patient on their ward each morning, and be available to speak to staff, however staff had noted that this was not in place. Uniform policy being adhered to is a current target area as part of infection control measures. Immediate actions were put in place with review by the Medicine Divisional Matron.

Alongside the EECS assessments, weekly matrons audits take place plus weekly ward manager audits. Assurances are provided through that process.

The Board were asked to receive assurance from the EECS assessments on the quality, safety, and standards of practice across the clinical areas and departments assessed. Where standards are below the expected level immediate actions are identified and progressed.

- 2.2** The Board **noted** the update with assurance received on consistently high standards being achieved.

#### **National Staff Survey Results**

The Deputy Director of HR and L&D Key presented the national staff survey results and highlighted key areas of note.

Nationally there has been an overall improvement in results, improvements across the NHS cover reward and recognition, learning, working flexibly, teamwork, compassionate leadership and whether staff have a voice that counts remain stable and there has been positive improvement across morale. Improvements were noted across most health and well-being measures, with a small drop in staff experiencing bullying, harassment and abuse across the NHS. More people are willing to recommend the NHS as a place to work and EDI scores were broadly stable nationally.

LHCH was ranked first in the country against all of the people promise themes which is benchmarked against acute specialist Trusts with 13 hospitals in this group. In addition, LHCH been ranked first in the country benchmarked against all NHS Trusts for a place to work, care is the top priority, staff engagement and staff morale. The Trust has maintained top position in Cheshire and Merseyside against 4 key indicators and improvements made in both WRES and WDES.

In terms of next steps, deeper analysis had started to help develop meaningful local action plans. The proposal is to follow the same governance cycle of last year, with draft plans to be discussed at the People delivery group, operational oversight to be provided at Operational Board at end of May 2024, and final plans and assurance to be provided to the People Committee in June 2024.

It was noted that the access to nutritional and affordable food at work was scored low. The Trust is working collaboratively through the Broadgreen Site Sub Committee to explore how we can improve food provision for staff.

It was questioned whether there is a plan to analyse the freeform comments for learning purposes. It was confirmed that themes will be identified and addressed. It was suggested that a focus on WRES and WDES be presented to the People Committee.

The CEO was keen to continue to aim for a high response rate again next year exceeding the levels from 2023.

- 2.2.1** The Board **noted** the report.

#### **Cheshire and Merseyside ICS: 2023 NHS Staff Survey Results**

This paper had been circulated to provide the context across Cheshire and Merseyside.

- 2.3** The Board **noted** the report.

#### **PLACE Report**

The Director of Nursing, Quality & Safety presented the Patient Led Assessments of the Care Environment (PLACE) report. The annual PLACE

programme was undertaken in September 2022 and November 2023. Assessments commenced in full following suspension during the Covid Pandemic.

The overall results were really positive and provided good assurance to the Board. An action plan has been circulated to all division leads, matrons, ward managers and departments in March 2024 in order to work through improvements that are required in specific areas. A mock PLACE assessment will take place in quarter 1 2024 - in preparation for a full PLACE assessment later in the year.

Following a question raised, it was noted that there has been focus both financially and environmentally to ensure ward areas and toilets and clinical areas are dementia friendly which have improved scores this year.

It was also noted that the food score has decreased however this does not correlate with follow up calls to patients who identify the food as excellent, therefore this suggests small numbers could decrease the score. Overall the response rate for food is good.

The Board of Directors received assurance on the Trust PLACE assessment results and received assurance that the action plan is being progressed to ensure all improvements are completed before the next full PLACE assessment in September 2024.

The Board **noted** the report.

### **3 Strategy and Development**

#### **3.1 Anchor Institute Update (incl. Green Plan)**

The Director of Risk & Improvement presented the Anchor Institute update. The Trust continues to have a proactive approach to all aspects of being an Anchor Institution. The Board were asked to note the update against each element of the Anchor Institution Framework including the Prevention Pledge / Social Value, Health Inequalities, and Net zero (Green Plan).

Good progress had been made in all elements of the Anchor Institute, and this will feed into objective setting for 2024/25 through the new Director of Strategy.

It was questioned whether there may be missed opportunities in moving away from disposable items of equipment to include gowns and theatre drapes. The Medical Director stated that there is ongoing work regarding a greener clinical environment. The Trust moved from disposable gowns to reusable gowns in theatre prior to Covid as part of a cost improvement programme which was also a positive environment impact. Reusable drapes are more complicated for various reasons.

It was noted that part of the challenge for the next 12 months is to identify the big ticket schemes together with building on work that has already taken place. The Director of Strategy will continue to provide updates going forward.

The Board **noted** the report.

### 3.2 Pensions Recycling

The Deputy Director of HR and L&D presented the pensions recycling report which outlines the annual review of the Trust pension recycling policy for clinical staff.

The policy was implemented in 2019 to acknowledge the increase in activity as a consequence of COVID and to address the pension and tax associated issues with earning additional income at that time. From 6th of April, the pension scheme annual allowance threshold and adjusted income threshold has increased which has reduced the uptake of this policy with only three live uses of the policy currently. Following discussion at the local negotiating committee it was agreed that the policy should be kept live for a further 12 months.

The Board of Directors was requested to note the contents of the paper and to consider the recommendation to extend the timeframe of the local Pensions Recycling policy on a short-term and time limited basis up to 31st March 2025, with the right to review, amend or withdraw the policy as necessary.

The Board **approved** the paper and **approved** the extension of the local pensions recycling policy.

### Membership and Community Engagement Strategy 2024-28

- 3.3 The Director of Risk & Improvement presented the membership strategy. The Membership and Communications Sub Committee led the development of the revised Membership and Community Engagement Strategy, which had been approved at the March 2024 Council of Governors. The refreshed strategy was circulated for information and ratification.

The Board **ratified** the Membership and Community Engagement Strategy 2024-28.

### Strategic Objectives Q4

- 3.4 The Director of Risk & Improvement presented the strategic objectives report. This report provided an update on the progress against the Trusts strategic objectives as at year end 2023/24.

LHCH objectives remain aligned to the 5 year strategy, patients partnership and populations. The paper demonstrates good progress at Q4. The 2024/25 objectives will be reset during Q1.

BB highlighted that the innovation strategy had been presented to the Executive Group and Operational Board but had not been circulated wider. LB confirmed that there had been a pause to enable the new team to reflect on the draft strategy alongside the Trust's strategy refresh. It was agreed to present the draft Innovation Strategy at the next Research and Innovation Committee for review and feedback.

**BB**

The Board **noted** the progress update.

## Targets and Financial Performance



### **Board Strategic Oversight Framework (SOF) Dashboard**

#### **4.1** The Chief Operating Officer explained that the SOF includes Operational Performance, Quality of Care, Financial and People KPIs.

JM provided an overview of operational performance at the end of month 11, with 4 indicators continuing to show statistically significant changes in performance and 8 indicators below target in month. Although a number of indicators are below target, performance is improving against a backdrop of workforce pressures. Three areas of ongoing risk were highlighted to the Board including the diagnostic position, cancer performance and long waiters.

In terms of diagnostics, the updated position in December saw the increase on waiting lists from provider to provider scans with a deterioration in performance but an improving trajectory. There is current focus on Radiology with workforce pressures and the team are being managed and supported.

Compliance with cancer targets has been impacted by a number of different factors, including workforce pressures, industrial action and achieving faster diagnosis. There have been challenges with CT guided biopsy and endobronchial ultrasound (EBUS). Q1 recovery plan for 2024/25 have been presented to the Integrated Performance Committee, albeit a number of risks continue to be managed and the Cheshire and Merseyside Cancer Alliance are cited on plans and trajectories.

The Trust is in a good position in terms of reducing long waiters. Mini mitral service are the main area for long waiters and referrals have now been suspended to that service in conjunction with Commissioners, and patients are being offered an alternative open procedure option. There are a number of mitigations and trajectories to support progress against reducing long waiters.

The Director of Nursing and Quality provided an update on quality of care metrics. The main area of concern is the MUST score of 2 to dietician referral. Ward managers and matrons have been working with the dietetic department and currently awaiting validation of the report. Whilst still performing below target of 95% the discharge summary metric has shown special cause variation of an improving trend which indicates the Trust is on the right path to achieving the target in the near future. The Sepsis target for 1 hour antibiotics has continued to consistently perform above the 90% target, although January 2024 figures were marginally lower this has shown improved performance in February 2024. Radiological alerts with a response document continues to perform below the target.

The Chief Finance Officer provided an overview of Finance at month 11, with the position reported as a £1,093k surplus, which is £274k better than plan in month. The year to date surplus is £10,671k which is £1,666k better than plan. Income associated with elective activity improved in February, but is still being affected by the continuation of staffing pressures in theatres. Private patient income continues to track positively against plan and Target lung scan income was also above plan in month. Pay costs were underspent in February by £332k and are underspend year to date by

£492k. Nursing costs continue to be within budget year to date despite over-establishment as a result of positive recruitment initiatives. The single largest adverse variance year to date is undelivered CIP. The Trust is on track to deliver the improved financial outturn agreed with the ICB as part of the national refresh. Capital allocation has been spent in full. The liquidity position remains strong with good level of cash in bank.

The Deputy Director of HR and L&D, provided an update on the People metrics. Sickness absence has increased in February 2024 to 5.54%. Long term sickness remains an area of focus. The business partner team have been working with managers to review of all cases to ensure there is robust management and support in place. Mandatory training has declined to 93.5% in February 2024 and this has been highlighted through Divisional Board meetings as a priority with focused effort on driving compliance back up to 95%. The position on mandatory training will be reviewed at the end of April and any areas below 95% will have recovery plans in place with support from the L&D team.

The Chief Operating Officer noted a positive performance across all 4 areas. A report will be presented to Board to review some of the drive and watch metrics for 2024/25. The COO stated that work is taking place to include research metrics into the SOF.

JM

The Board **noted** the performance dashboard.

## Governance and Assurance

### 5 High Risk Report (>15)

- 5.1 The Director of Risk and Improvement presented the high risk report which provided an update of risks with residual scores of 15 or higher along with the action plans in place to control and/or mitigate.

There are currently 3 risks that have a score of 15 or above. These related to The risk to patient elective activity. The risk to the timeliness of patients to receive an MR diagnostic scan across pressured service lines. The risk that clinical letters are not being sent to external partners including GPs and to patients.

The Board of Directors were asked to note the content of the report and be assured the Trust has systems and processes in place for the identification, management and escalation of risks. The Board will receive a full update on the risk regarding EPRO letters in the private meeting.

The Board of Directors **noted** the report.

### Board Assurance Framework

- 5.2 The Executive team have undertaken a full review and update of the Board Assurance Framework (BAF) at Q4. In summary, there are 2 residual risk scores that continue to be above the agreed risk appetite tolerance. The delivery of planned activity, performance activity and backlog recovery (BAF 2) and the 5 year capital programme (BAF 3) remain above appetite as in previous months. It should be noted that the BAF 3 risk has been mitigated in year (2023/24) but the challenge remains in terms of clarity of longer term

system funding. BAF 2 continues to be impacted by a range of factors including in year industrial action, staffing shortages and cancellations all impacting on activity.

The workforce risk (BAF 4) has been reduced to a residual risk of 12 with successful recruitment to key Board and senior leadership posts.

KWh noted that the Board of Directors had reviewed the risk appetite statement and BAF risks at the 6th March 2024 Board Strategy Day. The 2024/25 BAF will be developed and presented to the Board of Directors on 30th April 2024.

The Board was asked to review the updated BAF position at Q4.

The Chair suggested the wording for BAF 8 System architecture should be amended to reflect updates and KWh confirmed this was being reviewed for the 2024/25 BAF.

The Board **approved** the BAF.

KWh

### **Going Concern Report**

5.3

The Chief Finance Officer set out the context to the paper and asked the Board of Directors to confirm they have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future and there are no material uncertainties that cast doubt about ability to continue as a going concern that require disclosure.

As in previous years, the Trust's final accounts for 2023/24 will be prepared on a 'Going Concern' basis subject to approval of the Board of Directors. The report sets out the range of evidence which has been used to assess the Trust's Going Concern position.

The Board **approved** the position as set out in the paper regarding going concern.

### **Annual Review of Directors Disclosures**

5.4

The Board of Directors were asked to review the disclosures including register of Interests, NED independence and the fit and proper persons tests.

The exceptions were noted regarding Non Executive Directors serving more than six years and the assessment of independence that had taken place for Julian Farmer and Nicholas Brooks.

KWh noted that an updated report will be circulated to include Nicholas Brooks alongside Julian farmer as his third term had commenced in 2023/24.

The Board **noted** the update.

KWh

### **Code of Governance: Compliance Review and Disclosure Statement**

5.5

The paper provided confirmation of compliance with the new Code of Governance, highlighting two exceptions of compliance with the code relating to an externally facilitated well led review and the terms of office for

two Non Executive Directors exceeding 6 years. The paper setting out the full details of compliance had been reviewed by the Audit Committee.

KWh noted that following the well led self-assessment in 2023/24, the Trust intends to commission an external review in Q3 2024/25 aligned to the new CQC assessment framework.

The report also set out areas that continue to develop to further strengthen compliance around health inequalities and the Board has been sited on this on an number of occasions.

The Director of Risk and Improvement requested the Board of Directors to note the compliance with the Code of Governance, and to approve the disclosure statement with the addition of Nicholas Brooks exceeding 6 years in post for inclusion in the 2023/24 Annual Report.

The Board **approved** the disclosure statement.

#### **Gender Pay Gap Disclosure**

- 5.6\* The Deputy Director of HR and L&D explained that the purpose of report is to provide the Board of Directors with an overview of the Trust's gender pay gap data as per the statutory and legal requirement to publish this annually. Assurance was also provided that the statutory report has been published by 31st March 2024 deadline.

Progress continues to be made regarding the Trust's compliance with this legal requirement. Improvements have been made to close the gender pay gap, but the report highlights that further work is required to close the gender pay gap. The report and findings will be taken through the Equality and Inclusion Steering Group who will be tasked with reviewing the report and making recommendations on actions which will feed into the EDIB operational action plan. A progress update, alongside other equality, diversity, and inclusion interventions will be provided to People Committee in June 2024

The Board **noted** the contents of this report.

#### **Ratification of Trust Seal**

- 5.7 The Director of Risk and Improvement explained that the purpose of the paper is to ask the Board of Directors to ratify application of the Trust's seal to documentation relating to LHCH lifts 2 & 4 Contract.

The Board of Directors were asked to ratify the application Trust seal in respect of the above transaction.

The Board **ratified** the report, with the request that 'MJ' be amended to 'MK' within the report.

#### **Board Assurance**

### **6 BAF Key Issues Reports and Approved Minutes**

- 6.1 **Audit Committee:**  
***BAF Key issues for meeting held on 12th March 2024***

**6.1.1 Approved minutes for 9th January 2024**

The Board of Directors **noted** the BAF Key Issues report and last approved minutes.

**People Committee:**

**BAF Key issues for meeting held on 4th March 2024**

**Approved minutes for 5th December 2023**

**6.1.2** The Board of Directors **noted** the BAF Key Issues report and last approved minutes.

**Strategic Research and Innovation Committee:**

**BAF Key issues for meeting held on 27th February 2024**

**Approved minutes for 12th December 2023**

**6.1.3** The Board of Directors **noted** the BAF Key Issues report and last approved minutes.

**Integrated Performance Committee:**

**BAF Key issues for meeting held on 7th March 2024**

**Approved minutes for meeting held on 23rd October 2023**

**6.1.4** The Board of Directors **noted** the BAF Key Issues report and last approved minutes.

**Liverpool Trust Joint Committee:**

**Assurance report from meeting held on 7th March 2024**

**6.1.5** The Chief Executive explained that the Liverpool Trust Joint Committee meeting had focused on plans for a Liverpool Electronic Patient Record (EPR) which is a significant piece of work as part of a journey to improve digital connectivity across the system. The discussion was led by John Lewellen, Cheshire and Merseyside ICB Chief Digital Information Officer.

The Trust will engage going forward and a brief presentation had been delivered by the LHCH Chief Digital and Information Officer to the Trust's Operational Board. There was general consensus there would be benefits of joining up patient records across the city.

All providers in Liverpool with the exception of Mersey Care, had now signed a letter of commitment which will be sent to NHS England.

The Board of Directors **noted** the report.

**CMASST CiC:**

**Summary report for meeting held on 2nd February 2024**

**Summary report for meeting held on 1st March 2024**

**6.1.6** The Chief Executive explained that the main item of discussion was around financial planning for the next financial year.

The Board of Directors **noted** the reports.

**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.

**Evaluation of Board Meeting**

The Board of Directors confirmed that it was satisfied with the process, agenda and papers.

8

Glossary of acronyms was requested going forward and it was confirmed that the use of acronyms should be reduced. Jargon Buster to be circulated.

**Date and Time of Next Meeting**

RG

Wednesday 30<sup>th</sup> April 2024.

9

**Resolution to exclude the Public**

10

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