

Board of Directors (in Public)
Item 1.3

minutes

**Minutes of the Meeting of the Board of Directors
held on 30th April 2024**

Present:	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 Kuduvali	Medical 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
	Jane Royds	Chief People Officer
	Jay Wright	Director of Research
	Claudette Elliot	Non-Executive Director
In Attendance:	Ruth Gaunt	Executive Office Manager & Governance Lead
	Professor Shanley	Chair of NHS England commissioned independent review of Greater Manchester Mental Health Trust (Item 1.5)
	Ben Vinter	Director of Risk and Corporate Governance (to start in post on 10th June)
	Helen Martin	Head of Risk Management (Item 5.1)
	Ceri Thomas	Freedom to Speak up Guardian (Item 5.1)
Observers- Governors/ Staff/ Members of the Public:	Keith Wilson	Staff Governor
	Trevor Wooding	Patient Safety Partner
	Carol Ramsdale	Commercial Engagement Manager, NHS Professionals
	Darren Buckley	Regional Director, Siemens
	Ray Davies	Public Governor
Apologies for absence:	Julian Farmer	Non-Executive Director
	Anne Marie Davies	Associate Non-Executive Director

Action

1 Welcome and Opening Matters

The Chair opened the meeting and introduced those attending to observe the meeting. The Board members also introduced themselves.

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.

Claudette Elliott noted a declaration as Non-Executive Director at Pennine Care Trust.

All other participants confirmed that they had no interests to declare.

1.3 Minutes of the Board of Directors Meeting held (in public) on 9th April 2024 – for approval

The minutes of the meeting of the Board of Directors held on the 9th April 2024 (in public) were reviewed for accuracy and **approved** by the Board of Directors with the following amendment:

Julian Farmer noted as present and apologies. RG to amend.

RG

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:

- Board Strategic Oversight Framework (SOF) Dashboard. The Chief Operating Officer noted a positive performance across all 4 areas. A report is on the agenda to review some of the drive and watch metrics for 2024/25.
- Amended wording for BAF 8 system architecture to reflect updates.
- Annual Review of Directors Disclosures report updated to reflect Nicholas Brooks third term had commenced in 2023/24.
- Jargon Buster circulated to NEDs.

Updates were provided for the following actions:

- DIPC Infection Prevention data from other Trusts for benchmarking purposes - benchmarking work is complex and focus will remain locally within the organisation. Reports are presented to the Board quarterly. Action to be removed but will be reported to Board in the event of benchmarking being identified.
- Innovation strategy deferred to later in 2024.

1.5 Edenfield Review

The Chair welcomed Professor Shanley to the meeting to present the findings of the Independent Review of Greater Manchester Mental Health NHS Foundation Trust.

In September 2022, BBC Panorama highlighted abuse and humiliation of patients at the Edenfield Centre in Prestwich. Following the programme, NHS England commissioned an independent review, for which Professor Shanley chaired. Professor Shanley highlighted the key findings of the review.

System Engineering Initiative for Patient Safety (SEIPS) methodology was used, the first major review within the NHS using a SEIPS methodology. Key principles include; Healthcare is a complex, dynamic and interrelated system with many moving parts. "Work as done versus work as imagined". Restorative justice; most people do not come to work to do a bad job.

The review made 11 recommendations including: Patients, families and carers' to have stronger voice; Strengthening clinical leadership. Organisational culture; Workforce planning and managing risk; The quality of estate; Governance framework (including how information is used and governance resource); The clinical care model at Edenfield, including staff capacity and skills; The content and implementation of the Improvement Plan; Assurance around other services, including ligature risks and learning from deaths; A review of the role of the Provider Collaborative; A need for system-wide learning from Edenfield, including how partners work together to identify and respond to services in distress.

Comments and questions were welcomed. JM noted that the financial aspect had not come through in the presentation and asked how that might have potentially impacted due to significant periods of change and financial challenge. Professor Shanley explained that Manchester is a challenged system with a need for greater mental health resourcing however the team were unconvinced if this would have made a difference due to organisational culture.

NHS England has a good policy for managing transition and change and maintaining a focus on quality however no one paid attention to the policy. No one thought about the impact of organisational change. It was enormously distracted by the fact that the CQC rated the organisation as good.

KWh questioned whether there had been learning from Mid Staffordshire regarding a process to speak up within the organisation with an independent channel to take action. Professor Shanley explained that the freedom to speak up guardian was a director of HR which provided huge conflicts around that process, staff had raised concerns however nothing changed. There were whistleblowers to the CQC and other partners but nothing happened. All mechanisms were ineffective.

MK questioned why the clinical leadership did not function as well as it should have. Professor Shanley explained that differing accounts were heard, operational services became dominant, the notion of performance was the main mantra. Clinical leaders could not get a foothold as the rest of the Board did not recognise or value the contribution of senior clinical leaders. This played out through the rest of the organisation.

CE questioned whether the lines of enquiry were ever reflected upon by the Non-Executive team within the organisation and whether they had an opportunity to challenge the Executive team in terms of the inability to get

response to the lines of enquiry. Professor Shanley confirmed that this has improved post-Panorama.

The Chair thanked Professor Shanley on behalf of the Board and **noted** that the report provides much to reflect upon as a learning organisation.

1.6 Patient Story

The Director of Nursing, Quality & Safety presented the positive patient video story which highlighted the quality of care at LHCH. The story demonstrated the benefits of participating in research.

1.7 Staff Story

The Deputy Director of HR and L&D introduced the LHCH staff video story. Rony George joined the organisation in April 2022 working on Holly Suite and was then promoted to Clinical Practice Educator in 2023 following completion of a training programme which was created in response to WRES feedback to support internal promotion and the delivery of the equality, diversity and belonging strategy. Rony thanked all colleagues across the Trust who have supported him on his nursing journey.

CE praised the organisation for providing opportunities for all members of staff with a positive approach and the wraparound support in terms of being new to the country as well as the organisation.

JMa advised that it has been recognised that international nurses should be nurtured and have promotional prospects within the organisation and beyond.

The Board of Directors **noted** the patient story.

1.8 Chair's Briefing

The Chair highlighted focus nationally and regionally on financial and operational planning.

From an LHCH point of view, there have been several NED and Executive changes recently, with the majority of roles now filled. The Chief Digital & Information Officer will leave the Trust on the 19th July and the Director of Risk & Improvement will leave the Trust on 7th June.

Work will take place around Board development and the Chair thanked all for working through the difficult time.

The Board of Directors **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.

Urgent and emergency care is an area of focus, currently under significant pressure. A presentation was provided at the last CMAST leadership board meeting around mental health services and pressure this is putting on urgent emergency care.

The next CMAST meeting will take place on 3rd May where priorities will be signed off.

The CEO referred to a recent presentation by Charlie Cowburn, Practice Educator to the Operational Board which highlighted pastoral care for new staff.

The CEO, Director of Nursing, Quality & Safety and the surgical matron carried out a surgical walkabout. Conversations took place with managers who highlighted current challenges. Face to face discussions with wards and departments will continue.

The CEO referred to the recent presentation of employee of the month award to Mikey Miello. Mikey works in the Estates team and went above and beyond his duties.

CE questioned whether the system is meeting the deadline for the Right, Care, Right Person (RCRP). BV confirmed that Merseyside are on schedule with timescales and are comfortable with the plan.

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

2 Safety and Quality

2.1 Guardian of Safe Working-Annual Report

The Medical Director presented the Guardian of Safer Working Annual Report. There have been no exception reports in quarter 4. Only one exception has been received since August 2016.

At present LHCH has 51 trainees on the new contract currently on rotation at the Trust. All rota's are compliant with the rules within the 2016 contract.

Due to the lack of attendees at the Junior Doctor Forum, the Director of Medical Education (DME) is working with Guardian of Safe Working (GSW) champion to seek alternative methods.

The Chair noted the NHS England letter regarding improvement of working conditions for junior doctors, Margaret Carney to discuss at the People Committee.

MC

The Board of Directors **noted** the update

2.2 Deprivation of Liberty and Safeguarding (DoLS) Annual Report

The Director of Nursing and Quality presented the Deprivation of Liberty and Safeguarding (DoLS) Annual Report.

In July 2018, the government published a Mental Capacity (amendment) bill which will see DoLS replaced by the Liberty Protection Safeguards (LPS). This passed into law in May 2019. No further advice has been published as to when LPS will proceed.

A total of 150 DoLS applications have been made by either the safeguarding team or clinical teams in the ward/department areas across the Trust. There are 26 different local authorities across the catchment area where the

applications have been made to. Of the total 150 applications, all were classified as standard and urgent applications.

MCA and DoLS mandatory training is currently at 96.4% across the Trust and this meets the Trust safeguarding training requirements as set by the Trust ICB KPI requirements.

The Nurse Lead for Safeguarding is in the process of developing the Trust Strategy for Safeguarding in order to further support staff in the decision-making processes and provide guidance on legislation.

There are no new risks to be highlighted; all applications are completed in the patients EPR document and are reviewed on an individual basis.

MC enquired whether follow-up interactions occur with patients or caregivers collecting feedback on their experience of the process. JMa advised that the psychology service is offered to patients for those on critical care and conversations will take place with the psychology team around extending this to ward areas. Feedback is captured through the inpatient survey and all patients receive follow up calls. Positive or negative feedback is fed back to ward areas.

BB questioned whether nil response to applications from local authorities may be impacting on patients. JMa confirmed that the team consistently follow up applications and families are involved in best interest meetings so they fully understand what is taking place during their time at LHCH.

The Chair queried whether LPS demanding greater resource will be built into operational costs. JMa confirmed this will be reviewed in order to meet the requirement. An extra member of safeguarding team has been appointed and Angela McKenna has taken the safeguarding lead.

The Board of Directors received **assurance** on the process used within the Trust to determine patient's mental capacity in line with legislation under the Mental Capacity Act 2005.

2.3 Director of Infection Prevention and control (DIPC) Update Q4

The Medical Director presented the DIPC update for quarter 4. The annual report will be presented at the next meeting.

The surveillance of infections continues and all reportable infections are reviewed to identify trends or learning points, which are shared with relevant committees and groups. Work is ongoing to ensure the infection prevention quality and safety plan is fulfilled and that a robust audit programme is in place.

A number of working groups have been established to oversee issues related to the prevention or management of infection including; Cleaning Group, Sepsis Group, Antimicrobial stewardship Group and Surgical Site infection Group. Each group have their own audit schedule and action plans.

Benchmarking is difficult as the Trust collect data in much detail on the basis of validated criteria.

JW noted 12 areas audited for cleanliness with the average score of over 97% and questioned whether other areas should be audited to avoid complacency. MK confirmed that a more detailed cleanliness audit is provided to the Infection Prevention Committee on a regular basis. Other areas are included in that report.

The Chair commended MK on the report, noting learning points and comments being added to the report being useful to the Board.

The Board of Directors **noted** the contents of the report, the ongoing work and the continued low incidence of reportable infections.

2.4 LHCH Change of Commissioner Notice Letter

The Chief Finance Officer presented the LHCH Notice Letter. On 1st April 2024 formal contracting responsibility transferred from NHS specialist commissioning team to Cheshire and Merseyside ICB. This took place in regional clusters.

The Chair questioned the risks this would pose. JT advised that 2024/25 would be a transition year. NHS England managing commissioning team in the North West will still exist and will effectively work with the ICB's who will have formal responsibility. The plan is to establish a target operating model for the upcoming financial year, which will outline how local commissioning decisions will be handled.

JW highlighted a potential risk. Issues were caused several years ago with 'Care Closer to Home', many specialist commission services were lost to North Wales and LHCH continue to support them when they perform poorly in certain areas, i.e. complex devices. Cath lab contracts are based on complex device purchases. The contract is due to run for a further 4 years. John Morris, Divisional Medical Director for Medicine is working on this as part of the cardiology network.

JT agreed there are risks and opportunities with new arrangement and conversations will take place in the planning round for next year.

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

3 Strategy and Development

3.1 Quality Strategy Progress Update

The Director of Nursing, Quality and Safety provided a verbal update regarding the progress against the Quality Strategy. The quality and safety strategy will be refreshed in quarter 3. A meeting has been scheduled with those identified as having actions to ensure progress is made.

JMa and Dr Greenwood will attend Operational Board to start the new consultation process followed by consultation with stakeholders and members of the public.

The Board **noted** the update.

3.2 Digital Excellence Report

The Chief Digital Information Officer presented the Digital Excellence report. Significant progress has been made since the last reporting period. National and external reputation and profile is high and internal feedback from colleagues is positive.

Key headlines include the launch of National Digital Maturity Assessment for 2024; good progress with Digital Excellence delivery; good progress with clinical and nursing developments; and good operational performance.

The Chair raised concerns from the staff governor forum regarding digital systems not linking together. KWa advised that this is an age old issue with some organisations having more challenges than others. LHCH utilises an electronic patient record system alongside various specialist systems, with an integration system serving as the intermediary. JW advised that 'Share to Care' has provided much improvement in gaining access to patient records.

The Board of Directors **noted** good progress to date.

3.3 People Strategy Progress update (including EDIB, Recruitment and retention and Wellbeing)

The Chief People Officer presented the People Strategy Progress update. This paper provided the Board of Directors with assurance on the delivery of the LHCH People Strategy 2022-2025. The paper also provides a high-level progress update against each of the four strategy pillars: Recruitment & Retention; Learning & Development; Culture & Wellbeing; and Equality, Diversity, Inclusion & Belonging (EDIB).

Progress and assurance updates are provided to the People Committee on a quarterly basis. JR emphasised the organisation's commitment to nurturing a culture of well-being, belonging, and employee retention. MC suggested rag rating be included to provide additional assurance and emerging risks to be included in reports.

JR

The Board of Directors **noted** the content of the report and the actions that have been taken to support delivery of the LHCH People Strategy.

4 Targets and Financial Performance

4.1 Board Strategic Oversight Framework (SOF) Dashboard

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

Operational Performance

The Chief Operating Officer noted the good position at the end of month 12, maintaining standards during a significant period of industrial action and workforce pressures. Delivering a significant surplus to the system and delivering on a number of targets.

From an operational performance perspective, there are no new risks and the current challenges have been recognised in the plans for 2024/25.

VD noted LHCH diagnostic target slightly underperforming due to support provided to LUHFT and requested information to show LUHFT

improvements in order to provide an overall picture. JM agreed to report to Integrated Performance Committee as part of the CT biopsy review.

JM

Finance

The Chief Finance Officer noted the good performance in year. The month 12 position is a £681k surplus, which is £138k lower than plan in month. The surplus for the year is £11,352k which is £1,528k better than plan, and consistent with the forecast agreed with the Integrated Care Board. Income associated with elective activity improved again in March with the impact of the surgery recovery plan. Targeted lung scan income was also above plan in month.

Pay costs were overspent in nursing and theatres as a result of higher bank and agency spend. However, in aggregate across the year pay expenditure was consistent with the budget. The single largest adverse variance for the year related to the undelivered Cost Improvement Plan (CIP).

Quality of Care

The Director of Nursing, Quality & Safety noted the Sepsis target for 1 hour antibiotics has continued to consistently perform above the 90% target, and although January 2024 figures were marginally lower this has shown improved performance in February 2024. This indicator shows sustained special cause variation of an improving trend.

Excellent performance continues in Dementia and Delirium. 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.

Referrals to a dietician for patients scoring high risk has met target of 90% in month and shows special cause improvement further change to EPR is required to ensure performance is consistent in line with target.

There was good performance against the range of watch metrics with the majority achieving target and remaining in expected parameters.

The improve plans for VTE performance have demonstrated sustained performance over the last few months.

People

The Chief People Officer noted the good position in year. Mandatory Training is report at 93.5% and remains below the Trust target of 95%. Compliance has been highlighted through divisional board meetings with line managers being advised of the need to increase compliance during April.

There has been a marginal 0.25% increase in voluntary turnover and report is above the trust target of 10%. This was an expected increase given recent known senior changes and will be monitored alongside the retention action plan.

The HR Business Team continue to maintain a monthly sickness absence report which includes a plan against all cases of continued sickness absence. This data will be shared with the divisions for oversight and

escalation. The top reason for absence is stress and anxiety, however predominately external to work, mainly due to bereavement.

Action - JD questioned how liquidity metrics are calculated. JT to feedback. **JT**

JD questioned whether 3.4% absence target has ever been met. JR explained that the target has not been met even prior to Covid and the target should be reviewed.

4.2 Board Dashboard / SOF KPI Definitions and Performance Assignment Thresholds

The Chief Operating Officer presented the report which provided a view of the metrics included in the Trusts 2023/24 SOF and proposed additions for 2024/25. The metrics for the SOF need to be finalised by the end of May 24 to support reporting.

The Executive team have reviewed current indicators and request a further period of engagement prior to the Operational Board meeting in May 2024 and Board of Directors meeting in May 2024. The Executive team will review indicators in order to agree and refine against the national expectations and targets together with appropriateness of targets. For example sickness, 3.5% is the national target, however may need to be refined internally. Similar to 18 and 26 weeks, and whether a stretched target is appropriate. JM recommends an operational waiting time of 35 weeks, however will need to challenge the divisions with sustainable targets. Updated SOF to be presented at the next Board of Directors meeting.

JM

JD questioned whether there is an ability to scale metrics. JM confirmed that the drive and watch metrics provide the ability to pick out specific indicators, providing analyses against them, versus a number of watched metrics overall. The Board SOF is reflective of the Trust position and the sub-committees focus on the granular detail.

LB confirmed that research metrics will be added. It would be useful to identify which metrics are mandated and which metrics are local.

VD questioned whether drive and watch metrics have been agreed within the sub-committees. JM confirmed that as part of the process, the sub-committee review will follow from the Board review. NEDs to agree the correct metrics are included in the sub-committee SOF.

Health inequalities metrics to be developed as part of the SOF dashboard.

5 Governance and Assurance

5.1 Report of Freedom to Speak Up Guardian Annual Report, FTSU Board Self-Assessment & FTSU Policy

FTSU Annual Report

Helen Martin, Head of Risk Management and FTSU Guardian attended the meeting to present the Freedom to Speak Up Guardian Annual Report.

A total of 27 concerns were raised through FTSU in 2023/24. These are concerns raised directly with the FTSUG / Champions network. Concerns raised through other safety channels e.g. with line managers or through incident reporting, HALT, Safety Huddles are not logged through FTSU unless referred to the FTSU Guardian.

The national NHS Staff survey results 2023 show that LHCH is top in the country for being a place to work and staff engagement with strong responses in respect of raising concerns.

The processes for Freedom to Speak-Up is part of a well-established safety culture in the Trust where staff are encouraged to raise concerns. FTSU provides an alternative channel for staff to speak confidentially or anonymously with assurance that concerns will be escalated and workers will be supported while concerns are investigated. The FTSU Guardian's continue to maintain an active role in engaging with staff to maintain the profile of FTSU.

The Board of Directors receives quarterly and annual reports on the concerns raised through the FTSU internal network ensures oversight of issues raised across the organisation.

The FTSU Guardians will continue to engage with the National Guardians Office (NGO and regional network to ensure LHCH continues to lead the way in relation to best practice.

JD questioned how many cases were upheld as being bullying or patient safety. HM confirmed that most cases result in miscommunication or misunderstanding. Those raising concerns are content with the process and resolution. None felt detriment to speaking up. KWh added that FTSU is not about upholding concerns, but about ensuring these are fully investigation and action taken as required to resolve.

The Board of Directors **noted** the assurance provided in the 2023/24 FTSU annual report, demonstrating that local FTSU arrangements are in place and continue to meet best practice.

FTUS Self-Assessment

Ceri Thomas, FTSU Guardian attended the meeting to present the FTSU self-assessment. This had been brought together through engagement with a range of people.

The self-assessment against the reflection tool demonstrates that FTSU is well embedded with clear processes and procedures. The team continue to work on the priorities for 2024/25, raising awareness of speaking up and exploring the barriers.

CE noted the link between the health and wellbeing strategy and working with networks within the organisation feeding into the inclusive nature. Working with cultural barriers has been set as a priority for the coming year.

The Board of Directors **approved** the FTSU Self-Assessment.

FTSU Policy

The Director of Risk & Improvement presented the FTSU policy. The policy was updated against national guidance last year, therefore the refresh of the policy includes updated contact details to include new member in post.

KWh confirmed that FTSU has been one of the highlights of her current role at LHCH and thanked the FTSU team.

The Board of Directors **approved** the Freedom to speak up policy.

5.2 Communications Calendar

The Chief People Officer presented the communications Calendar which has been updated by Matt Back, Head of Communications.

The Board of Directors **noted** the communications calendar.

5.3 Flu Campaign Report*

The Director of Risk and Improvement presented the Flu Campaign report. The 2023 Flu and Covid vaccination campaigns commenced September 2023 and concluded March 2024. A number of methods had been deployed to ensure staff had full access to the vaccination and a comprehensive communications strategy accompanied the campaigns. The LHCH flu campaign vaccinated 50% of eligible staff (51% in 2022), and the covid campaign achieved a vaccination rate of 16% of staff (31% in 2022).

MK advised that flu particularly in patients, is monitored closely. Discussion took place around vaccination fatigue and the scare of vaccinations together with the benefit/ risk ratio.

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

5.4 NHS Constitution Compliance Report

The Director of Nursing, Quality and Safety and the Chief People Officer presented the NHS Constitution Compliance Report. Overall, the Trust has assessed itself as compliant in all areas of the NHS Constitution with the exception of the element in relation to access to services. This has been driven by the impact and continued national response to the Covid 19 pandemic. The impact of the Covid pandemic has resulted in many patients being delayed in accessing the treatment they have required during this time and patients are now waiting longer to be treated. During 2023/24 LHCH has had a continued focus on safely managing waiting lists, ensuring clinical prioritisation of patients and has demonstrated good progress in recovering the backlog of patients and reducing waiting times.

The detailed assessment against the standards had been reported to the People Committee and Quality Committee respectively.

The Board of Directors **noted** the assessment of compliance in all areas within the NHS Constitution with the exception of the rights for access to services as a result of the impact of the covid 19 pandemic.

5.5 Board Assurance Framework

The Director of Risk and Improvement presented the Board Assurance Framework. The Board Assurance Framework sets out the risks facing the

Trust in delivering its strategic objectives and is a key tool to focus actions and assurance against these risks.

The Board Assurance Framework (BAF) has been fully reviewed with risks updated to reflect the strategic objectives for 2024/25, as well as the operating environment and external factors. Two risks remain above the Trust maximum tolerance and these have been evaluated to ensure that the Trust is taking appropriate action to mitigate these risks (it should be noted that both risks are affected by external factors which are not fully within the Trust's control but we continue to take actions to reduce the risks).

Key changes include risk wording updated to include commissioning changes and the provider landscape. Additional controls have been added for commissioning arrangements and system digital collaboration. Gaps in controls and assurance, and actions updated to include system workforce, finance and operational expectations, control and scrutiny. System implications continue to be recognised within specific risks, with these prominent in finance, operational effectiveness, workforce and digital themes. There is also a separate risk in respect of the system collaboration and landscape, and LHCH positioning as a strong system partner. This also reflects the changes to CVD Board, CMAST Cardiology Provider Alliance and CVD Prevention Board.

The Board **approved** the opening BAF for 2024/25.

5.6 High Risk Report (>15)

The Director of Risk and Improvement presented the High Risk Report. The risk registers contain significant risks identified as having potential impact on the Trust objectives. These include risks identified and escalated by the Clinical Divisions.

There were three high risks included within the report.

There is a high risk relating to patient elective activity. JM advised that the risk will reduce in the context of the improved scrub nursing position. The March 2024 position is reflective of this from an elective activity perspective.

There is a high risk in respect of the timeliness of patients to receive an MR diagnostic scan across pressured service lines (mainly pacemaker and supervised cardiac lines). There is a risk to patients exceeding 6 week diagnostic target for referral to diagnostic scan and not achieving DM01 target and 6 week target for all patients.

JM noted Radiology as the main area of focus as a Trust with a significant number of workforce pressures across all staff groups. A renewed focus will support the department. A discussion took place at operational board regarding a Cameran review that took place externally to try and provide guidance and support.

The final high risk was that of clinical letters not being sent to external partners such as GP's and patients. This was related to a specific time period and a more detailed update would be discussed as part of the Serious Incident Report in the Private Board meeting.

Risks are reviewed monthly at each Divisional Board meeting and quarterly by the Risk Management Committee.

The Board of Directors **noted** the content of the high risk report and actions which clearly triangulated with other reports received.

5.7 Risk Appetite Statement

The Director of Risk and Improvement presented the Risk Appetite Statement. The Trusts risk appetite statement supports the risk framework as it sets out the appetite for risk themes and the maximum tolerance for risks. The risk appetite statement has been updated following the discussion at the Board strategy day in March 2024.

Key aspect of changes include workforce as an open risk with a risk tolerance of 12. System collaboration wording has been changed which aligns to the BAF and discussion around refreshing the strategy.

The Board of Directors **approved** the risk appetite statement for 2024/25.

6 Board Assurance

6.1 BAF Key Issues Reports and Approved Minutes

6.1.1 Quality Committee

BAF Key Issues for meeting held on 16th April 2024

Approved minutes for meeting held on 9th January 2024

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

NB informed the Board that there are no new or emerging risks. Discussion took place regarding the role of the quality committee over research and innovation. It was agreed that quality and safety are paramount in research and innovation. Jenny Crooks provided a presentation on the preparedness for the MHRA inspection that will take place. NB understands the MHRA report will be reported directly to the Board.

6.1.2 CMAST CiC:

Summary report for meeting held on 5th April 2024

Legality of Board Documentation and Decisions

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

Laboratory Information Management System (LIMS) and Full Business Case (FBC) to be added to jargon buster. **RG**

7 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.

8 Evaluation of Board Meeting

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

9 Date and Time of Next Meeting

Wednesday 28th May 2024.

10 Resolution to exclude the Public

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

DRAFT