

Board of Directors (in Public)
Item 1.3

minutes

**Minutes of the Meeting of the Board of Directors
held on 28th May 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
	Julian Farmer	Non-Executive Director
In Attendance:	Ruth Gaunt	Executive Office Manager & Governance Lead
	Sue Sutton	Out of Hospital Lead (Item 1.5)
Observers- Governors/ Staff/ Members of the Public:	Keith Wilson	Staff Governor
Apologies for absence:	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.

The Chair acknowledged that this would be the final Board meeting for both Karan Wheatcroft and Julian Farmer.

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.

JD noted a declaration as Non-Executive Director at Primary Care 24 which will end on 29th May.

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

1.3 Minutes of the Board of Directors Meeting held (in public) on 30th 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

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:

- Action 2 – Joan M to arrange a date the MET team presentation is presented to Quality Team.
To be presented in July. Action complete.
- Action 5 - Minutes to be amended to reflect JF attendance.
Action complete.
- Action 7 - Board Strategic Oversight Framework (SOF) Dashboard
JD questioned how liquidity metrics are calculated. JT to feedback
Action complete.
- Action 11 - Laboratory Information Management System (LIMS) and Full Business Case (FBC) to be added to jargon buster.
Action complete.

An update was provided for the following action and the action was carried forward.

- Action 10 - The Executive team will review indicators in order to agree and refine against the national expectations and targets together with appropriateness of targets. To include research metrics. Amendment to the SOF for month 1 has been made. Under development for research and health inequality metrics.

All other actions were due for review at future dates.

1.5 Department presentation – Therapies

Sue Sutton, Out of Hospital Lead attended to present the Therapies update. Therapies staffing consists of Physiotherapists, Occupational Therapists, Exercise Physiologists, Dietitians, Speech and Language, Support Workers and Admin support. Service provision includes; stroke and complex rehabilitation including OOHA, cystic fibrosis, medicine, critical care and surgery, pulmonary rehabilitation (The breathe programme), exercise

physiology – cardiac and pulmonary rehab, ACHD, AF and palliative care – occupational therapy.

Challenges include workload of on-call staff and reluctance to take additional hours, increased complexity and acuity of patients, new service specification for pulmonary rehabilitation, redesign of CF service from in-patient to outpatient model. Recruitment and retention. SS highlighted solutions, team achievements, opportunities, risks and incidents relating to therapies.

The future would include a Chief AHP in the Trust, opportunities for AHPs, accreditation of Pulmonary Rehab, potential 7 day working (physiotherapy) and pre-habilitation.

JM emphasised the importance of considering therapies when expanding or changing services. The impact on the department should be carefully evaluated. Levels of activity need to align with support services and address quality concerns.

NB raised concerns about the availability of all 20 physiotherapists for weekend and on-call coverage. SS explained that weekends pose challenges due to limited capacity for patient rehabilitation. All respiratory physios have on-call duties as part of their contracts. A 3-month training period for on-call responsibilities is mandatory after qualifying.

Joan M expressed full support for exploring how Allied Health Professionals (AHPs) can have inclusive development opportunities within the organisation. CE raised a question about the team's involvement in addressing the staff survey. SS clarified that the team has identified key themes from the survey and is discussing the best way to proceed.

JW noted that the higher degree program at John Moore's University offers academic support and fees for AHPs, particularly focusing on the BAME population. JW expressed interest in discussing this matter with the physio department.

The Board of Directors **noted** the presentation as an outstanding example.

1.6 Patient Story

The Director of Nursing, Quality & Safety presented the positive patient video story emphasising excellent care received at LHCH. The patient discussed the impact of receiving news about significant surgery on both themselves and their family.

VD questioned whether mental health support is provided to patients before discharge. Joan M confirmed that psychology care is provided within intensive care and the Trust are looking to expand this service for other patients and families in different situations.

NB highlighted the prolonged healing of the donor site and inquired about the use of endoscopic vein harvesting for all patients. MK clarified that the option is currently available for a limited number of patients at higher risk of wound infections. The goal is to eventually extend this approach to almost all patients, but this will require time for training and skill development.

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

1.7 **Staff Story**

The Chief People Officer presented the LHCH staff video story. Rebecca Dobson, Consultant Cardiologist and Kelly Howarth, arrhythmia specialist nurse describe the work they have done regarding ECG review feedback to patients and how this had led to the diagnosis of cardiovascular disease that perhaps wouldn't have been detected.

The ECG service was established to enhance the safe delivery of cancer therapy for Clatterbridge patients. Certain cancer treatments can potentially impact the heart. The cardio-oncology services involve collaboration among various healthcare professionals.

The service was established in September with the goal of improving patient services and safety. Kelly is the sole provider responsible for reviewing approximately 1-8 ECGs per week.. Over the last 6 months, Kelly has reviewed over 300 ECGs. Kelly identified and escalated 40 abnormalities, leading to improved patient care and safety.

JW highlighted the lack of confidence among specialist Trusts when dealing with matters outside their specific areas. Additionally, the benefits of collaboration between specialist Trusts were emphasised, as it allows them to gain expertise from different domains.

CE emphasised the need to address health inequalities. MC highlighted the importance of maintaining service reliability despite a small team. LB suggested the model of care could be replicated elsewhere.

JW advised that a regionwide protocol exists for managing immunotherapy-induced myocarditis. LHCH has received patients through this protocol, specifically under the heart rhythm team. The protocol has been successfully adopted across the region.

BB congratulated Rebecca, Kelly and colleagues on their fantastic work.

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

1.8 **Chair's Briefing**

The Chair highlighted focus nationally and regionally operational planning and system challenges.

VD attended the CMAST leadership group. A recording from each of the 4 workstreams update will be circulated and VD requested feedback whether this would be useful.

VD attended the CMAST Chairs group with focus on productivity improvements, new controls regarding staff recruitment and reflections on CMAST going forward.

VD attended the Liverpool Trust Chairs update and will provide an update at the Private Board meeting.

Chairs visits have occurred in the areas of CCU, Pulmonary Function and Outpatients. Annual one-to-one meetings with governors take place with 6 undertaken this year. NEDs and the Chairs appraisal have taken conducted.

MC held a NED led development session for governors, regarding people committee. Volunteers week will take place 3rd-9th June.

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.

All 5 Trusts have agreed to sign up to a single laboratory information system which will digitally enable reporting.

MK attended the national board, chaired by the NHSE Medical Director. The board defines operating model, provides strategic direction which will feed down through to ICBs. 4 key areas include CVD prevention, cardiac, stroke and respiratory. Progress has been made around the less ideal progression made for recovery for spirometry with the North West being bottom of the league table. NHSE to work with local systems to identify support required for expanding a number of virtual wards for heart failure.

A clinical permissioning policy has been submitted regarding Mitral transcatheter edge-to-edge repair (TEER) which is a relatively new approach to fixing mitral valves. Manchester is currently the regional center, however there is room to expand this service to other organisations.

Operational Board have been requested to look at activities in those programmes and will present to Board in due course.

All Trusts received a letter regarding publication of the Infected Blood Inquiry Report. To be reviewed internally and fed back to various structures.

NB raised concerns about the risk associated with patient-initiated follow-up (PIFU). JM clarified that providers must take responsibility for managing governance and risk when placing patients on a PIFU list. Patients can initiate follow-up without requiring additional referrals from primary care.

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

2 **Safety and Quality**

2.1 **Infection Prevent Control (IPC) BAF update**

The Medical Director presented the IPC BAF update. The report details evidence and level of compliance with the standards identified in the Board assurance framework (BAF) for infection prevention and control. The overall level of compliance is good.

All standards in the BAF will be included in the annual plan for 2024/25 to ensure evidence will be available to demonstrate compliance on an ongoing basis.

The IPC BAF is being managed proactively and the relevant standards will be included in the annual programme for 2024/25. There is good compliance with the majority of the standards and where any areas of non-compliance have been recognised, actions to address these have been identified. Some actions remain beyond the control of the infection prevention team but these issues have been highlighted to the appropriate departments.

The Board of Directors **noted** the contents of the report and the accompanying IPC BAF.

2.2 Director of Infection Prevention & Control (DIPC) Annual Report

The Medical Director presented the DIPC annual report. This report details the infection prevention and control arrangements, and discusses the achievements that have been made to prevent healthcare associated infections (HCAIs) during the financial year 2023/24.

HCAI remain low in the Trust. Surgical Site Infections (SSI) has been a particular area of focus in the year 2023-24 and a robust multi-disciplinary action plan is in place to keep SSI to a minimum. The deep infections, which can cause more harm, are down to very low levels. Data collection is very robust and based on established criteria.

This paper provides assurances that audit, monitoring and education programmes are in place to prevent healthcare associated infections. With a robust surveillance system in place to monitor infections which has ensured that any issues that have arisen have been addressed in a timely manner.

The surveillance programme for infections has continued and indicates that overall, Trust attributable infections remain relatively low. SSI have been an area of focus and has seen improvement over the year.

There are 3 sub-groups which report into the Infection Prevention committee to include Water Safety Group, Decontamination Group, Antimicrobial Stewardship Group. The Infection Prevention team (IPT) also attend meetings and contribute to other groups within the Trust.

NB noted the outstanding results and questioned the mechanisms of reporting infections. Joan M advised that the Infection Control team receive information directly from clinical surveillance software. Each patient receives an in depth review which is reported to clinical surveillance software preventing information being missed. The infection prevention lead nurse also meets with the microbiologist weekly.

VD noted decontamination of the patient environment using Ultraviolet-C and questioned whether this is in collaboration with Broadgreen. MK advised that the contract with Steris for decontamination of instruments is due to end and will be renegotiated. The Broadgreen on site decontamination unit is not accredited. **Action** - JM to discuss decontamination collaboration at the joint Operational Group.

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

3 Strategy and Development

No items to report.

4 Targets and Financial Performance

4.1 Strategic Oversight Framework

The Chief Operating Officer presented the Strategic Oversight Framework. Proposal for research indicators to be provided by the research and innovation committee. Further understanding is required around metrics from health inequalities perspective.

Operational Performance

The Chief Operating Officer noted the good position at the end of month 1. At the start of the 24/25 financial year, a number of indicators and baselines have been refreshed to support appropriate monitoring going forward. 4 standards are showing below the national KPI, however expected against historic trends and workforce pressures. Recovery plans and mitigations are in place across indicators which are monitored closely against clinical risk.

Elective activity in month was above plan for the Trust and following significant scrub nursing vacancies in 23/24, core capacity has been delivered through Theatres.

Cancer Performance is reported 1 month in arrears and all cancer standards continue to be challenged by workforce pressures. In March all Cancer standards were non-compliant to the national targets, however no clinical risk has been identified due to wait times. Significant improvements have been noted in month for the 31 day position. JM noted the faster diagnosis good position, 10 days for CT guided biopsy and EBUS.

Consistent focus is being placed on long waiters, with 65 and 52 week waiters being monitored weekly by the Divisional teams. DM01 (Diagnostics) showed a slight deterioration in April with full recovery expected to run into Q2 of the financial year.

VD noted issues with other organisations regarding provider to provider referrals and questioned LHCH position. JM confirmed that challenges were noted in December when waiting lists changed. All provider to provider scans are being monitored appropriately based on wait times. Stress MRI remains a continued areas of concern due to capacity constraints.

VD questioned the process and criteria for watch and drive metrics. JM confirmed that metrics are agreed by Execs and Non-Execs during sub-committee meetings and are reviewed quarterly.

Quality of Care

The Director of Nursing, Quality & Safety noted the sepsis target for 1 hour antibiotics has continued to consistently perform at or above the 90% target, with performance above target for 3 consecutive months. This indicator shows sustained special cause variation of an improving trend. There were no serious incidents, never events or grade 2 or above pressure ulcers observed due to lapses in care in April. One occurrence of a grade 3 pressure ulcer acquired at LHCH was reported in March 2024. 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 did not meet target of 90% in month and shows common cause variation of passing or failing target. Improvements associated with changes to EPR to support compliance requires monitoring.

Good performance against the range of watch metrics with the majority achieving target and remaining in expected parameters. Number of falls continues to be within the expected variation. As previously reported additional measures have been taken with an aim to reduce this consistently. Numbers of formal complaints continue to be low. The improvement plans for VTE performance have demonstrated sustained performance over the last few months

LB highlighted the complaints team as exceptional.

MK noted challenges in receiving data for RAR's, improvements have been made with further work taking place in order to achieve 100% accurate data. Digital solutions are helpful once the data quality is correct.

Finance

The Chief Finance Officer noted the month 1 position Achieved £700k surplus against £1.1m surplus, shortfall of £383k. Similar to the same period in the previous year, some driven by unmet CIP. Pay run rate is on plan, productivity and workforce control has been consistently on plan for several months. Currently checking non-pay expenditure of stock levels in theatres and Cath labs to ensure timings are aligned as there have been more purchases than expected for month, causing a pressure of approximately £200k in month. JT identified CIP as the most significant risk.

People

The Chief People Officer noted that the appraisal window opened on 1st May, the team aim to improve on last year's final position. The next Live Well Work Event is scheduled for July, which will include an expanded offer of diagnostic testing for staff. Divisional Staff Survey Action Plans have been developed and presented to People Delivery Group on 7th May 2024. Mandatory training reports have seen a marginal increase and reports at 94% against a target of 95%. A review is being undertaken around core and appropriate training. Turnover reduced in April, currently 10%. Sickness increased in April, currently 5.24% against a target of 3.4%, the target has not been reached in the last 12 months. Top reasons for absence include stress and anxiety, muscular skeletal and seasonal cold and flu. The team are undertaking a review of bereavement leave reporting to ensure staff are provided with the correct level of support. Full report to be presented to the People Committee.

Governance and Assurance

5

5.1 Annual Equality & Inclusion Update incl. Workforce Race Equality Standard (WRES / Workforce Disability Equality Standard (WDES)

The Chief People Officer presented the annual Equality & Inclusion update including WRES / WDES report. The report provides a summary of EDIB

activity over the last 12 months as outlined in the EDIB action plan and provides early insight into our WRES/WDES performance based on the 2023 staff survey results. Full update to be presented to the People Committee. The report is intended to demonstrate that good progress has been made against delivery of the EDIB strategy, complying with national requirements and public sector duty under the Equality Act.

Development of a new integrated action plan helps drive this work forward, but as the agenda remains significant, capacity is likely to become a challenge with the strategic EDI role currently being an added responsibility to a substantive role and with an additional risk of single point of failure which will be monitored. MC requested further information regarding capacity. JR clarified that due LHCH being a small Trust, staff members have dual roles which can create tight schedules. JR will continue to monitor resource.

The monitoring and review of equality related activities for both patients and workforce is undertaken through the Trust's established EDIB Steering Group and assurance on activity and progress against the EDIB action plan will be provided to the People Committee on a quarterly basis.

MC raised concerns regarding the increase in staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months and questioned the process to be taken to ensure BAME staff of not experiencing disproportionate impact from patients and public. JR agreed that a deeper understanding is required, however staff are supported and are encouraged to report in order for issues to be addressed. Work will take place around a zero tolerance approach, raising awareness of consequences. To be reflected in the action plan.

The Board **noted** the contents of this report and supporting appendices.

Board Assurance Framework

- 5.2 The Director of Risk and Improvement presented the Board Assurance Framework. Full update was presented at the previous Board meeting. Q1 update to be provided in July.

JT advised that the annual financial planning has not yet concluded and will be reviewed at IPC to ensure the final position is understood.

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

High Risk Report (>15)

- 5.3 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 two high risks included within the report, both presented to the Board previously.

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.

Risk in respect 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. Risk score be amended on the risk register.

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.

5.4 Integrated Incidents, Complaints and Claims (IICC) Report – Q3/Q4 2023/24

The Director of Risk and Improvement presented the Integrated Incidents, Complaints and Claims (IICC) Report. This report provides the Board of Directors with quantitative and qualitative analysis of reported incidents, complaints and claims (IICC). The report focusses on Quarters 3 and 4 2023/24, compared with Q1/Q2 of 2023/24. Work has taken place to develop the report further as a triangulation piece to include key messages within the executive summary.

KWh highlighted key messages within the report. Incident reporting, learning from incidents, complaints and claims and improving the safety culture, remains a priority for the Trust. Incident reporting culture has been maintained in terms of the number of incidents reported and the top 5 themes include administration processes, medications, communication, patient falls, and documentation. Swarm discussions, rapid review and MDT reviews are being undertaken with a focus on learning, improvement and culture. There were 3 incidents classified as severe harm and there has been one Patient Safety Incident Investigation (PSII) in Q4. There were 4 RIDDOR (reporting of Incidents, Diseases and Dangerous Occurrences Regulations) reportable incidents in Q3 and Q4.

The number of complaints remains low, although for 2023/24 there was a slight increase to the previous year. A number of complaints related to cancellations/ waiting for surgery, and work is being done to review and reduce cancellations and improve communications to those on the waiting list. There were no concerns / actions from the coroners cases closed in Q3 and Q4. The issues raised through Freedom to Speak Up (FTSU) were largely related to systems and processes, health and wellbeing, working practices, and staff values and behaviours. Organisation learning arrangements are strong with additional developments achieved through the embedding of the Patient Safety Incident Response Framework (PSIRF). In terms of patient experience, the Trust received excellent results in the NHS Adult inpatient survey. Follow up calls continued to be made to all patients who had an overnight stay in the Trust and these provided positive feedback across a range of indicators, and a small number of areas identified for improvement. Patient engagement events have been held and the quality priorities for 2024/25 agreed.

The Board of Directors were asked to receive assurance that mitigation to prevent harm to patients and staff, by the reporting of and learning from reported incidents, complaints, claims and patient experience events continue to be monitored through the governance structures within the organisation.

VD noted that medication errors were increasing and Closed Loop was understood to reduce these incidents. Joan M highlighted the importance of a good reporting culture and the review of incidents for severity. The Chief Pharmacist realigned incidents based on their severity. KW reported a downward trend in the Closed Loop part of the process.

The Board of Directors received **assurance**.

- 5.5 Organisational Learning from Deaths – Q4 update and Annual Report**
- The Medical Director presented the Organisational Learning from Deaths – Q4 update and annual Report. The Trust complies with national guidance and populates the mortality dashboard. There is a rigorous review process for all deaths within the Trust. Learning from these deaths is shared widely through Divisional Boards, clinical audit meetings and also by uploading relevant presentations to a mortality SharePoint page which can be accessed at any time.

The Divisions track action plans arising from learning points. This data will be triangulated with Dr Foster (Telstra Health) data, InPhase, complaints, coroner's cases and audits.

There have been 64 deaths in the Trust between January and March 2024. For comparison the total number of deaths in the Trust for Q4 2022/23 was 50. 55 of these deaths have been through the complete mortality review process. No death has been classified as avoidable.

There were a total of 214 deaths in the year 2023-24. Of these, 205 have completed the review process. The remaining outstanding reviews are all from Q4. There was one avoidable death in the year, which was in Q3. In comparison, there were a total of 223 deaths in 2021-22 and 182 in 2022-23.

MK asked for feedback on the new report, and it was agreed that the report is well written. The positive changes to the mortality review process have received favorable feedback through themed learning.

Discussion took place around 'failure to rescue' which is an ongoing concern across the NHS for which LHCH has given focus over several years. The Board of Directors were informed that further in-depth granular detail is incorporated within the MRG process.

NB inquired about quantification or analysis of deaths on a waiting list. MK confirmed that waiting lists are assessed for potential harm and the team is actively enhancing the process by regularly monitoring patients to detect any deterioration. The division undertake a full review of deaths on the waiting list.

Action - Neil Coulson, Consultant Anaesthetist to attend Quality Committee to provide a presentation around the MRG process together with a focus report regarding deaths on the waiting list.

The Board of Directors **noted** the contents of the report and received **assurance** that mortalities within the organisation are scrutinised as per requirement.

Board Assurance

6

BAF Key Issues Reports and Approved Minutes

6.1.1

CMAST CiC

6.1.2 Summary report for meeting held on 3rd May 2024.

The Board of Directors **noted** the summary report. Further detail to be circulated.

Integrated Performance Committee

6.1.3 BAF Key Issues for meeting held on 22nd April 2024 and approved minutes for meeting held on 3rd March 2024.

The Board of Directors **noted** the BAF key issues and approved minutes.

Quality Committee

6.1.4 Joan M noted the changes to the Terms of Reference membership.

The Board of Directors **approved** the terms of reference.

Strategic R&I Committee

6.1.5 BAF key issues for meeting held on 14th May 2024 and approved minutes for meeting held on 27th February 2024.

Discussion took place around the position of university hospital status which will be moved forward by Jenny Crooks, Deputy Director of Research and Innovation before leaving the Trust. Clatterbridge are also in the process and it was agreed that it would be useful for the two Trusts to work together with this before submitting applications.

JW explained that £200k research funding is no longer an essential criteria. JW understands LHCH fulfil all other criteria.

The Board of Directors **noted** the BAF key issues and approved minutes.

Legality of Board Documentation and Decisions

7

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

8

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

Date and Time of Next Meeting

9

Tuesday 11th June 2024 – Board Strategy Day.

Tuesday 25th June 2024 – EO Accounts approval.
Tuesday 30th July 2024

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.

DRAFT