

minutes

Board of Directors (in Public) Item 1.3

Minutes of the Meeting of the Board of Directors held on 28th January 2025

Present:	Margaret Carney	(Trust Vice Chair - Chair)
	Liz Bishop	Chief Executive
	Joan Matthews	Director of Nursing, Quality & Safety
	Ben Vinter	Director of Risk & Corporate Governance
	Nick Brooks	Non-Executive Director
	Manoj Kuduvalli	Medical Director
	Tom Pharaoh	Director of Strategy
	Sarah Barr	Chief Digital & Information Officer
	James Thomson	Chief Finance Officer (left meeting at 11am)
	John Doyle	Non-Executive Director
	Bob Burgoyne	Non-Executive Director
	Jonathan Mathews	Chief Operating Officer
	Jay Wright	Clinical Director of Research
	Claudette Elliot	Non-Executive Director
In Attendance:	Ruth Gaunt	Executive Office Manager and Corporate Governance Lead
	Angela Hale	Physiologist
Observers- Governors/ Staff/ Members of the Public:	Keith Wilson	Staff Governor
	Margaret Roberts	Governor - Public Constituency, North Wales
	Dawn Dhillon	Strategic Account Manager, Abott Medical UK Ltd
	John Kendall	Staff Governor – Registered Medical Practitioners
Apologies for absence:	Val Davies	Chair

Action

- Welcome and Opening Matters**
The Chair opened the meeting and introduced those in attendance observing the meeting.

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. All participants confirmed that they had no interests to declare beyond those that may already be known and on Trust registers.

1.3 Minutes of the Board of Directors Meeting held (in public) on 26th November 2024 – for approval

The minutes of the Board of Directors meeting held on the 26th November 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.

- Draft refreshed strategy to be presented at the next R&I committee meeting. To be discussed as agenda item.
- Joan M to request assurance around trajectory of low complaints being a positive; to be added to the narrative of quarter 3 and 4 reports. Update - Referenced in the SOF, to be incorporated into quarterly report.
- Update to be provided on progress of development of the SOF for health inequalities, anchor institutions and research and innovation. TP advised that the health and inequalities group is meeting and progressing well. Useful conversations have taken place with the analytics team regarding data in general. Health Inequalities progress report to be provided to the Board in March.
- Consider appropriate measures to capture brand awareness going forward. Brand awareness will continue under LAASP, to be built into the LAASP work program.

All other actions were due for review at future dates.

1.5 Department presentation – Cath Lab Physiologist.

Manoj Kuduvalli, Medical Director introduced Angela Hale, Physiologist who attended the meeting to present the Cath Lab, TAVI physiologist department presentation.

AH explained that she has been in the role for 12 months, focusing on structural and ACHD services, which have expanded significantly with procedures like TAVI and Pascal valve replacements. It's been a rewarding journey, and the team feel well-supported, especially during high-risk procedures. Thorough briefings and debriefings are conducted to ensure the team understand their role and feel confident, regardless of the outcome.

Transcatheter Aortic Valve Implantation (TAVI) has evolved from an open-heart procedure to a minimally invasive technique performed in a catheterisation lab. The physiologist plays a crucial role in monitoring the patient's haemodynamics throughout the procedure, including blood pressure, heart rate, and oxygen levels. They ensure patient stability, anticipate complications, and assist with pacing the heart to facilitate accurate valve placement. The physiologist's expertise is vital for safe and effective

valve deployment, managing arrhythmias, and responding to emergencies. Their contributions help reduce the need for post-procedure echocardiograms and support quicker patient discharge.

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

1.6 Patient Story - TAVI

Joan Mathews, Director of Nursing, Quality & Safety introduced the patient story. The patient enrolled on the Target Health Check Programme and highlighted the care received and the unexpected early diagnosis faced despite being a healthy individual and the subsequent outcomes. A procedure took place via laparoscope, the patient was discharged and was pleased to be able to return to his cycling hobby. The patient noted the excellent care received.

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

1.7 Staff Story

Jane Royds, Chief People Officer presented the LHCH staff video story. Mark Murphy has been a security officer for 13 years. He joined the blood service, becoming one of the first men in that role. After 11 years, Mark switched to a security officer position at LHCH. His duties include patrols, checking on staff, and handling challenging situations, such as dealing with aggressive patients. Despite the challenges, Mark finds the job rewarding and values the supportive work environment.

JM noted the work undertaken to educate security teams around mental health how it is portrayed and how it may exhibit in our patients .

The Board of Directors **noted** the positive staff story and a good example of challenges faced by staff.

1.8 Chair's Briefing

The Vice-Chair updated the Board that the recruitment process for the new Chair has been finalised. David Flory, also the ULHG Chair and will take up the role of LHCH Chair from 1st April. The process for the replacement of the CEO has been agreed and is in process.

Val Davies attended the CMAST presentation provided by Rachael Jones, CEO of the Voluntary, Community and Social Enterprise Group. VD felt there were learnings to be taken from this sector. There are almost 20,000 organisations across the CMAST area and more than 30% work in health and social care. VD has arranged to meet with Rachael Jones to discuss opportunities of closer working.

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

1.9 CEO's Report

Liz Bishop, CEO report provided an update on a range of issues. The report was taken as read and LB highlighted key items of note.

LAASP work is in progress, meeting monthly.

There have been no further contacts regarding cyber threat. Advice has been received from the regulators for data protection that their investigation incident has been closed. SB explained that in order to understand the level of detail regarding data that had been extracted but not published, a piece of work will take place under the guidance of legal teams with KPMG (a national partner in this area). The conclusion is expected this week.

National report on the event is due to be received week commencing 27th January and will be presented to the Audit Committee who will assure the Board thereafter.

Regarding CMAST and provider collaborative work, LB informed the Board that efforts to integrate the two provider collaboratives are still ongoing. Feedback will be provided as the work progresses.

Letter detailing indicative planning guidance was received on 6th January from NHSE around elective recovery, one of the actions required to be undertaken included assigning an Executive Director who will be responsible for improving waiting times and experience. Jonathan Mathews volunteered for this role. National target of 65% patients waiting less than 18 weeks by March 2026.

JT advised that the financial framework to enable guidance is expected today, therefore payment for capacity and flow is unclear. The guidance makes reference to a new NHS oversight and assessment framework.

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

2 Safety and Quality

2.1 DIPC Quarterly Report Q3

Manoj Kuduvalli, Medical Director presented the DIPC (Director of Infection Prevention and control) /HCAI framework Report, quarter 3. MK noted the typographical error in section 3.1, cases July to September to be amended to October to December.

MK noted the small surge of MSSA bacteremia cases, all within the internal threshold, occurring in the same quarter. The team reviewed these cases and identified several learning points. Additionally, there were three C. diff infections this quarter, potentially linked to a patient previously cared for in a specific room. The team reinforced clinical standards and emphasised the importance of preventing contamination.

Respiratory viruses were noted but not significant. Cleaning standards and audit programs continue as normal, with no new surgical site infections reported. Cardiac surgical infection work is ongoing, and sepsis metrics are satisfactory. The infection prevention team receives strong support from microbiology colleagues and holds monthly catch-ups to drive the agenda.

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

2.2 Guardian of Safe Working-Quarterly Exception Report Q3*

Manoj Kuduvalli, Medical Director presented the guardian of safe working quarterly exception report. 2024/2025 quarter 3 report on safe working hours following introduction of the 2016 contract for Junior Doctors.

There have been no exceptions during quarter 3. The post of Guardian of Safe Working is now vacant due to the partial retirement of the current postholder. Following a recent recruitment campaign, one applicant has applied for the post and the interview will take place as soon as possible.

The Board of Directors **noted** the safe working hours compliance.

3 Strategy and Development

3.1 Research and Innovation Strategy Progress

Director of Research, Jay Wright presented the research and innovation strategy progress.

The research interim strategy was written two years ago after experiencing a financial loss in research due to Covid. The strategy focused on people, process and finance. The team concentrated on people to ensure safe research could be delivered fast. Head of Research organised several processes for researchers to present their projects for early-stage reviews before the site initiation visit, ensuring a robust pipeline.

JW noted that the chance to transform routine clinical work supported by excellent data into publishable material is crucial, therefore, the process into account data and IT teams as an area of future development. The team are in an improved position with improved capability.

JW advised that 'time to set up' is expected to be the new financial target. This is a high-level objective set by the NIHR CRN: Percentage of closed to recruitment commercial contract studies which have achieved their recruitment target is 80%. Percentage of closed to recruitment non-commercial studies which have achieved their recruitment target is 80%. Information is presented each month at the operational research committee.

JW noted the dip in finance performance in December and the two mitigating factors.

The previous research strategy requires updating. JW planned to write the new LHCH strategy, however the LAASP collaboration specifically requested Trusts not to have individual strategies until the LAASP strategy for research and innovation is written. JW understands LAASP will form a small part of a bigger city C&M region offering. LHCH should be involved in the decision making process.

Following discussion, the Board agreed that LHCH will collaborate with LAASP on their overall research strategy and contribute their own input. LHCH will handle metrics and delivery through the Research and Innovation Committee, addressing any issues that arise. The strategy will be reviewed and updated as needed. Innovation will be monitored closely. MK noted the potential LAASP research collaborations.

The LAASP portfolio board next week will help set the milestones and timeline. Details will be shared with the Board.

BB highlighted issues raised regarding the volume of published papers by the Director of the Local Centre of Cardiovascular Science (LCCS), suggesting the extent to which the centre is addressing its objectives and how this is aligned with LHCH goals needed to be considered..

The Board agreed importance of LHCH exploring any risks around the number and scope of publications. Governance to be agreed through the Research and Innovation Committee with recommendations and priorities fed back to the Board at the appropriate point.

NB inquired about robotic surgery and JW advised that robotic surgery had produced little research and is currently static in terms of the clinical service. MK advised clinical and research prospects put forward for the robotic programme were fairly ambitious and suggested there are lessons to be learned, All should be mindful of projected gains put forward for certain business cases with increased check and challenge. LB suggested this be addressed through the clinical audit programme.

The Board **noted** the Research and Innovation Strategy Progress.

3.2 Quality Strategy Progress Update

Director of Nursing, Quality and Safety, Joan Mathews provided a verbal Quality Strategy Progress update. PSIRF principles are being aligned into the draft quality strategy document. Strategy is scheduled to be approved by the Quality Committee in March.

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

4 Targets and Financial Performance

4.1 Strategic Oversight Framework

JM noted that the SOF details Trust performance for overall elective, finance, workforce and quality.

Operational Performance

Jonathan Mathews, Chief Operating Officer noted the operational performance. At the end of month 8 the Trust delivered more activity than the last couple of years, however impacted by non-elective performance. Long waiter position is moving in the right direction regionally. Waiting list size has increased, mainly in the medicine division however no areas of concern in terms of increasing the long waiters position. JM commenced the diagnostics team in the radiology department noting an improved position continually due to support form staff to carry out additional sessions. JW agreed that the improved position is noticeable as a clinician.

Cancer performance for October was fully compliant in all areas. Winter pressures will see that impacted in month 9 and 10 position.

CE requested an update regarding outsourcing of minimital. JM advised that there are very few long waiting in the system. In terms of reopening the minimital list, a sustainable position is required with 3 trained surgeons.

The training plan for the third surgeon is ongoing and expected to be signed off by the end of the financial year. The Trust are no longer outsourcing Spire capacity for the minimital service. Additional outsourcing was signed off by the Executive team for cardiac waiting lists overall, 92 patients were contacted and 15 accepted. To be discussed further during annual planning meetings.

Quality of Care

Joan Matthews, Director of Nursing, Quality & Safety highlighted key areas of note. Pressure ulcers with no identifiable lapse in care continue as a positive picture. Discharge summary on the day of discharge metric continues to perform just below target of 95%. Pharmacy technicians have been added to the discharge tick list which is expected to improve compliance. The number of formal complaints continue to be low. Slight recovery was noted in Family and Friends Test (FFT) metric performance. The data continues to be reviewed with the analytical team and ward teams granular level results continue to look positive. The number of falls continues to be within the expected variation, there was a slight rise in December, however acuity and occupancy was high during that month.

MC inquired if there has been a comparison of the number of complaints pre-Covid. Joan M explained that there were approximately 30 complaints during the year prior to Covid, with no specific themes.

JD noted that the Call to balloon time consistently failing the target due to national and regional issues and questioned the impact on patients recovery. MK suggested this does have an impact on the patient recovery, the target of 150 minute national target is reasonable, however this is a national problem. Patient harm is difficult to quantify due to the nature of presentations. Work is taking place regionally for Door to balloon time, and LHCH currently achieve above the national target. MK noted that primacy PCI is one of the regional priorities.

Finance

James Thomson, Chief Finance Officer noted month 8 year to date position as a £8,387k surplus. This is £761k lower than plan, but reflects continued improvement from the shortfall seen in the opening months of the year.

Key variables being managed include understanding activity position and reimbursement through the Elective Recovery Fund (ERF) mechanism, currently working with the ICB to understand the forecast.

The Surgery Division has a significant under-performance against its elective plan, driven by significant levels of emergency demand. There are non-pay budgetary pressures driven by overspends in Theatres and Cath labs, driven in part by emergency surgery activity and higher prices. Drugs price inflation is also contributing to the overspend.

CIP target, 74% achieved, with 96% identified.

Cash position remains stable. Frequent meetings are taking place to ensure schemes are prioritised in relation to capital allowance.

People

Jane Royds, Chief People Officer noted month 8 position. Turnover reports above 10%, which demonstrates continued efforts to ensure workforce stability and retention of talent. Sickness absence increased to 5.21% in November, marking an area of continued concern. While long-term absences have decreased, there has been a significant rise in short-term absences, particularly due to respiratory illnesses.

A slight decline in mandatory training compliance was expected, largely due to the recent update of the Safeguarding Level 1 module. Efforts are underway to address this and increase compliance, currently 89.74%. Appraisal compliance, 88% against a target of 90%.

Joan M advised that discussions are taking place to review mandatory training modules and the possibilities of other methods for essential training.

5 Governance and Assurance

5.1 Report of Freedom to Speak Up Guardian Q3

Ceri Thomas, Freedom to Speak Up Guardian and Helen Martin, Head of Risk Management/Freedom to Speak up Guardian attended the meeting to present the Report of Freedom to Speak Up Guardian.

Quarter 3 saw an increase in speak ups from quarter 2 and is at a similar level to quarter 3 last year. This coincides with speaker up month in October where it is usual to see an increase in cases, national Guardian's Office reports that quarter 3 has had the highest number of cases per quarter years since 2018.

The majority of cases in quarter 3 had an element of staff safety or well-being and were in relation to processes. All are being addressed by appropriate channels. 1 case had an element of alleged racism which is undergoing an HR process and 1 has an element of implied discrimination and bias. Learning the approaches are currently being explored in this case.

FTSU compliments existing speak-up safely policies and processes within the Trust, providing an alternative channel for staff to speak confidentially or anonymously. The policy provides assurance that concerns will be escalated, and workers are supported during the process and investigations.

The FTSU Guardians supported by the network of champions continue to maintain engagement with the staff to raise the FTSU profile, support staff who have raised concerns, record and follow-up cases raised.

The FTSU Guardians will continue to provide quarterly and annual reports on the number of concerns raised through the FTSU Network and any common themes to the Board of Directors and the National Guardian's Office. Learning from cases will continue to be reviewed and shared appropriately. The FTSU guardians will continue to maintain engagement with the National Office and regional networks to ensure that national updates are cascaded and implemented.

As Executive FTSU lead, BV expressed thanks to the Board for their consistent consideration and sponsorship of the local FTSU approach. Across the ICS, quarterly focus and regular Board attention are not

guaranteed.. BV noted the importance of speaking up as it resonates with and provides meaning for staff through regular coverage, exposure, and support.

The Board of Directors **noted** the quarter 3 report and received **assurance** that local FTSU arrangements are in place and to the best of our knowledge continue to meet best practice.

5.2 Board Assurance Framework

Ben Vinter, Director of Risk and Corporate Governance presented the Board Assurance Framework. The report highlights a consistent position with regards to residual risk scoring across the BAF metrics.

Previous discussion took place regarding the Trust impacts on workforce, considering both the immediate perspective and a broader system view. It was suggested in earlier discussions that the Trust maintain the wider system risk at a narrative level, which is consistently reflected in the report. This approach continues, with a slightly higher scoring proposed within that system context.

Three residual risk scores continue to track above the agreed risk appetite tolerance. The delivery of planned activity, performance activity and backlog recovery, the 5-year capital programme and digital transformation and service delivery resilience.

The Board were asked to note and consider the rework undertaken on BAF 9 which represents a repositioning of the objective, controls and actions. This proposal is considered to more accurately reflect the position of the Trust in the digital area. It is recognised that any changes are a choice for the Board to consider within the context that it is proposed. A 'greyed out' version of BAF9 as reported and tracked to this point is also shared with the Board. Within this context it is important to note that a discussion is scheduled to take place in February considering potential objectives for 2025/6 and the Trust's risk profile in that regard.

SB noted that the digital BAF is in relation to transformation and cyber. Controls in the previous BAF were not fully appropriate and required re-writing, reflecting the current position. Risk appetite to be discussed during the February strategy day.

BV stated that discussion took place at the November Board, following the audit committee's consideration of changes to the description and associated classification of assurance. The Board agreed to the update of the Board cover reports to reflect the new assurance arrangements.

The Board of Directors **reviewed** and **approved** the report noting the enhancements made to descriptions and definitions of assurance statements contained within the BAF.

5.3 High Risk Report (>15)

Ben Vinter, Director of Risk and Corporate Governance presented the High Risk Report. The report provides an update of risks with residual scores of 15 or higher along with action plans in place to control and/or mitigate them. There are currently three risks with a score of 15 or above relating to MRI

diagnostic capacity, clinical data security and the structural integrity of the surgical corridor.

It was recognised the more regular updates should be provided on developments regarding EPRR core standards, which is now embedded within the report. BV explained that this does not incorporate a new set of activities for the Trust, just a different way of reporting.

NB noted disappointment in the surgical corridor being reinstated onto the risk register and inquired if there have been lessons learned. BV understood that the organisation chose between a remedial or full refit, with the latter requiring a substantial investment. Unfortunately, this activity tends to be cyclical in nature. JM advised that remedial works are annually reviewed. There will be a point where remedial works will not be sufficient and will be addressed as part of the LAASP strategy.

SB advised that a review of ISCV clinical data security will take place. Planning for provisional funding for next year will incorporate the risk. The team have been requested to review controls noted within the risk and re-write them. There is evidence of mitigation around this risk. Risk score to be reviewed.

The Board of Directors **noted** the content of the report and received **assurance** that the Trust has systems and processes in place for the identification, management and escalation of risks.

5.4 Comms Strategy Update

The Chief People Officer, Jane Royds presented the Comms Strategy update. The purpose of the report is to keep Board of Directors informed and provide a high-level update on Trust communications activities during quarter 3 (October-December 2024). JR noted the successful LHCH Grand Awards 2024. Extensive strategic communications work required and delivered. Good social media output with positive engagement across channels. Extensive divisional support delivered. JR noted further progress required in quarter 4 around PR opportunities and brand building, where possible, within limited resources.

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

5.5 Medical Revalidation Annual Report

The Medical Director, Manoj Kuduvalli, presented the medical revalidation annual report. There are no significant risks associated with the Medical appraisal and revalidation process within the Trust. Outstanding appraisals will continue to be closely monitored and the measures implemented to address non-engagement with the appraisal process are proving effective.

MK noted 100% appraisal compliance for 2023-24. Feedback was received from NHSE that the Trust's ratio of appraisers per doctor is high. A recommendation was made for to review this going forward and this is being considered as part of the overall policy and process review.

In addition, recommendations from the NHS England Assurance Visit, combined with the collaboration between the RO, Medical Appraisal Lead,

and the Medical HR team provides confidence that the Medical Appraisal and Revalidation process will continue to strengthen and improve.

Following discussions with the Trust's senior leadership team, changes were identified for the timeframes of appraisals to facilitate improved integration between the appraisal and job planning process. The previous appraisal window of September to March, has been amended to April to November. New timeframes will aid the process by ensuring appraisals are approved ahead of job planning thus helping inform the job plan.

The Board **noted** the report as evidence that the Trust is compliant with the processes necessary for medical revalidation.

6 Board Assurance

6.1 BAF Key Issues Reports and Approved Minutes

6.1.1 CMAST CiC:

- Summary report for meeting held in December 2024 and January 2025.

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

6.1.2 LAASP Joint Committee

- **Summary Report from meeting held on 20th November 2024**

The Board of Directors **noted** the summary reports. Reports will continue to be presented to Board.

6.1.3 Audit Committee

- **BAF Key Issues for meeting held on 15th January 2025**
- **Approved minutes for meeting held on 8th October 2024**

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

JD explained that the terms of reference for review of the digital service were provided to the audit committee. The audit committee recommended them to the Board. Task and finish group will include JD, CE and NB.

JD noted 'significant progress' as an example of assurance provided within committee reports. JD asked each committee lead to review their reports and determine if they are receiving assurance from them or accepting the wording. MC suggested this be included as part of committee annual reviews.

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

6.1.4 Quality Committee

- **BAF key issues for meeting held on 14th January 2025**
- **Approved minutes for meeting held on 18th October 2024**
- **Integrated Incidents, Complaints and Claims Report**

The Board of Directors **noted** the BAF key issues and approved minutes and Integrated Incidents, Complaints and Claims Report.

6.1.5 People Committee

- **BAF key issues for meeting held on 2nd December 2024**
- **Approved minutes for meeting held on 9th September 2024**

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

6.1.6 Strategic Research & Innovation Committee

- **BAF key issues for meeting held on 10th December 2024**
- **Approved minutes for meeting held on 10th September 2024**

BB advised that a set of metrics for the SOF were agreed and approved at the December strategic Research & Innovation Committee, to be translated into the appropriate format.

BV advised that BB's term concludes at the end of March and the recommendation accepted by the NEDs is for MK, Medical Director to Chair the Strategic Research & Innovation Committee for the interim period.

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

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

Tuesday 25th March 2025.

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.