Wirral University Teaching Hospital
NHS Foundation Trust

19 February 2019

Council of Governors

Wirral University Teaching Hospital NHS Foundation Trust

Council of Governors
Tuesday 19th February 2019
4.30 p.m.
Boardroom, Education Centre, APH

AGENDA

1.	**Apologies for Absence** Chair	v
2.	**Declarations of Interest** Chair	v
3.	**Minutes of Previous Meeting (12th December 2018)** Chair	d
4.	**Matters Arising** Chair	v
5.	**Patient Story** Director of Nursing and Midwifery	v
6.	**Chair's Business** Chair	v
7.	**Key Issues** All	v
8	**Governance**	
8.1	**Audit – External Audit Fee 2019/20** Chair of Audit Committee	v
8.2	**Options for Quality Indicator (Quality Accounts 2018/19)** Director of Quality & Governance	d
9	**Trust Performance**	
9.1	**Quality & Performance Dashboard** (as reported to the Board 30.1.19) Chief Executive	d
9.2	**CQC Action Plan Assurance** (as reported to the Board 30.1.19) Chief Executive	d
9.3	**Quality Committee** Chair's Report	p

9.4	**Board of Directors' Meeting Minutes 28th November and 19th December 2018** Chair	d
9.5	**Board of Directors' Meeting, 30th January 2019 Update** Chair	v
10	**Standing Items**	
10.1	**Any Other Business** Chair	v

COUNCIL OF GOVERNORS UNAPPROVED MINUTES OF MEETING HELD ON 12th DECEMBER 2018

BOARDROOM EDUCATION CENTRE ARROWE PARK HOSPITAL

Present:

Sir David Henshaw	Chair *
Paul Dixon	Public Governor
Mandy Duncan	Stakeholder Governor
Steve Evans	Public Governor
Sheila Hillhouse	Public Governor
Eileen Hume	Public Governor
Richard Latten	Staff Governor
Allen Peters	Public Governor
Norman Robinson	Staff Governor
Frieda Rimmer	Public Governor
Ann Taylor	Staff Governor
Angela Tindall	Public Governor

In attendance:

Christopher Clarkson	Non-Executive Director
Jayne Coulson	Non-Executive Director
Janelle Holmes	Chief Executive
David Jago	Director of Finance
Helen Marks	Director of workforce
Anthony Middleton	Chief Operating Officer
Nikki Stevenson	Medical Director
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery
Andrea Leather	Board Secretary
Julie Adley-Sweeney	Membership Manager

Apologies:

Natalia Armes	Director of Transformation and Partnerships
Paul Charnley	Director of Informatics
John Fry	Public Governor
Fadil Hannan	Stakeholder Governor
Kathy Hodson	Stakeholder Governor
Sue Lorimer	Non-Executive Director
Paul Moore	Director of Governance and Quality
Rohit Warikoo	Public Governor

*Denotes part of the Meeting

Ref	Minute
CoG 17-18/0109	**Apologies for Absence** Apologies were noted as above.
CoG 17-18/011	**Declarations of Interest** Dr Richard Latten advised that he had recently made an addition to the declarations

Ref	Minute
0	register to include his work at Liverpool University.
CoG 17-18/ 0111	**Minutes of the Previous Meeting** The minutes of the previous meeting held on the 19th September 2018 were approved as an accurate record.
CoG 17-18/ 0112	**Matters Arising** There were no matters arising
CoG 17-18/ 0113	**Patient Story** The Director of Nursing and Midwifery provided the council with the above. The story was that of a patient, who had been diagnosed with prostate cancer and had not been provided with enough support or information surrounding his condition. There was also a lengthy wait throughout his treatment, which caused a great deal of anxiety and distress. Despite his own experience, which had proven to be both, exhausting and frustrating the patient was keen to help future patients going through a similar ordeal. He has joined the WUTH volunteers to support urology department patients. He has also agreed to work as a patient partner, in conjunction with professionals on the Always Event project from January 2019.
CoG 17-18/ 0114	**Chair's Business** The Chair welcomed all attendees to the meeting, in particular new Public and Staff Governors. He also introduced Dr Nikki Stevenson, newly appointed Medical Director and Mrs Andrea Leather, Board Secretary. The Council was advised of the development of a Wirral Command Centre involving the Trust, Wirral CCG, Wirral Community Trust, Cheshire and Wirral Partnership and both GP Federations. The purpose of the Command Centre is to develop, agree and implement plans to support the Health Economy throughout the Winter period. A log would also be kept in the Command Centre to ensure an accurate, evidence based audit trail.
CoG 17-18/ 0115	**Key Issues** The Council was advised that the recent Values and Behaviours Sessions, led by the Executive Team were proving to be successful and that overall the Trusts relationships with partners on the Wirral was very positive. The Council was informed that the Trust currently had 115 medically optimised patients unable to be discharged and there were 27 outstanding care packages in the Community. The Trust however, was confident in its plans for Winter preparedness for A&E and elective care.
	Governance
CoG 17-18/	**Recruitment of the Chair** The Chair left the meeting at this point and this item was then chaired by the Senior

Ref	Minute
0116	Independent Director. The Council was informed of the process undertaken prior to the Nominations Committee Meeting on 5th November 2018, by a recruitment company, GatenbySanderson. The council was advised that there had been two candidates, only one of which was recommended for the role; which had led to the Nominations Committee making a recommendation to the Council of Governors. The Trust informed NHSI of the decision and some concerns were raised as to the, somewhat limited response surrounding candidacy. It was requested that the recruitment process be extended and this decision was agreed by the Council. A further extension of Sir David Henshaw's term as Interim Chair has been agreed until February 2019.
	Performance
CoG 17-18/ 0117	**Trust Performance** The Council received a presentation during which information was provided on the Trust's performance in relation to key targets. In areas where the Trust was failing a target, further narrative and information was provided in terms of action being taken. The Chief Executive reported that the A&E 4 hour standard was currently rated as red and the 18 Weeks Standard currently rated as green. The Council was informed that all cancer targets had been met and remained green for Q2, 2018/19. The Chief Executive was pleased to report that Infection Control Indicator, which had previously been rated amber, was now rated green. The Council was advised of the provision of 30 beds on the Clatterbridge site and the extra wrap around support provided at Arrowe park for patients coming in via the A&E Department. The Chief Executive reported that bed occupancy was running at an average of 94.1%, this however included paediatrics and maternity beds. In terms of acute beds occupancy was in excess of 99%. The Council was advised that since receiving a CQC rating of "Requires Improvement" the Trust had developed an action plan which contained approximately 120, must do, or should do key elements. Progress on these elements was provided to the Board on a monthly basis. The Council was informed that there had been one reported Never Event, therefore this area had been rated as red. It was reported that Patient Satisfaction in the Friends and Family In-Patients Test remained green and the Staff Satisfaction Engagement score remained as amber. The survey also showed that Workforce Attendance was rated red at October 2018. Qualified nurse vacancies had moved from a rating of red to amber and the Council was advised that the Trust was currently reviewing its recruitment plan.

Ref	Minute
	The Council was advised of the Trusts planned income and expenditure deficit position, which was currently rated red in Month 7 (October) as it had a planned target of £17.4m and an actual figure of £19.3m. Progress against the savings plan and cash position were, however rated green and currently on track. The Council was informed of the wide range of risks which the Trust faces; which if not mitigated could compromise its corporate objectives. The Trust had, however done a considerable amount of work to develop a clear picture of both, internal and external risks.
CoG 17-18/ 0118	**Workforce Assurance Committee** The Council received a presentation from the chair of the above committee. The Council was advised of the remit of the newly established committee which had first convened in early May 2018. Areas currently under review by the committee included the following: **Recruitment and retention** – particularly band 5 nurses and looking at innovative ways to attract staff. **Workforce planning** – taking a more strategic view and piloting a work force planning tool in the Women's and Children's Department. **Health and wellbeing** – underpinning many outcomes within all areas of the Trust. **Culture** – recognition that this is determined by leadership and re-launch of the Freedom to Speak Up Campaign to aid prevention of an unhealthy culture.
CoG 17-18/ 0119	**Board of Directors' Meeting Minutes 25th July, 27th September, 1st November 2018** The Council received the minutes of the above meetings.
CoG 17-18/ 0120	**Board of Directors' Meeting** **28th November 2018, Update** The Chair provided a brief update from the most recent Board of Directors' Meeting.
	Strategy & Development
CoG 17-18/ 0121	**Developing New Pathways and Services** The Director of Nursing and Midwifery provided a presentation relating to four key areas within the Trust that had been improved by patient input. The Critical Care Unit (CCU) had developed a patient diary for staff and visitors to write in, on a regular basis as many patients felt that they 'lost' a section of time when they were very poorly. Patients have found the diaries to be a great comfort. Changes had also been made to lighting, noise and clocks, all based on patient feedback. A number of developments have been made within Cancer Services, including staff

Ref	Minute
	focus groups, a web page, support café and training for managers in how to help their staff through difficult times. The Trust has recently focused on nutrition and hydration, with the introduction of finger foods and snack fridges. Governors took part in a workshop which taste tested a newly proposed menu, prior to implementation. Patients were also asked 'What matters to you at mealtimes' and the feedback provided was used to influence the conditions surrounding mealtimes. Maternity Services have seen a number of developments following patient input. The Seacombe Birth Centre was created in collaboration with our external stakeholders. A Mums and Midwives shop has also been opened in a local shopping centre, to provide support and advice. The Applepip Suite and the Butterfly Suite have both been created with the help, support and fundraising of bereaved parents.
Standing Items	
CoG 17-18/ 0122	**Any Other Business** There was no other business
CoG 17-18/ 0123	**Date and Time of Next Meeting** Tuesday 19th February 2019 at 4.00pm.

……..……
Chairman

……..
Date

Council of Governors	
Agenda Item	**8.2**
Title of Report	Options for Quality Indicator (Quality Accounts 2018/19)
Date of Meeting	19th February 2019
Author	Paul Linehan
Accountable Executive	Paul Moore
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Patient safety Effectiveness
Level of Assurance • **Positive** • **Gap(s)**	Gap – poor progress with timely discharge of patients Positive –improvement with Malnutrition Universal Screening Tool
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	Approval Required
Data Quality Rating	Silver - quantitative data that has not been externally validated
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

1. Executive Summary

In preparation for 2018/2019 Quality Account, the council of governors are asked to select their preferred from the 3 indicators listed below for the local quality improvement indicate for 2019/20

1. VTE (Venous Thromboembolism) target of 80 % completion of the patient pathway (admission to discharge);
2. No moves at night, and reduced bed moves at any time for patients with a diagnosis of dementia (high risk patient group for falls);
3. Safe management of patients in non-ward areas.

The above options are aligned to the draft quality strategy for WUTH which is focused upon delivering a positive patient experience and progressively safer care, which is clinically effective and reliable. Progression in the above domains will provide improvement in the quality and safe care of inpatients at WUTH.

2. Background

Quality Accounts (QA)are annual reports to the public from providers of NHS healthcare. The purpose of QA is to encourage boards and leaders of healthcare organisations to demonstrate commitment to continuous quality improvement and to be transparent with progress.

The proposed local priorities have been selected based on gaps in clinical management pathways, poor patient experience, incident reporting and potential risk to quality

3. Key Issues/Gaps in Assurance

2018/2019 quality improvements priority position:

- Implement the SAFER bundle to improve patient flow and ensure safe discharges;
  The safer bundle target of 33% has not been achieved throughout 2018/2019 to date. This is monitored through the Quality performance dashboard. Quarter 3 average is 15%

- To ensure patients nutritional needs are identified and met;
  There is significant progress of completion of assessment of patients using the Malnutrition Universal Screening Tool (MUST). Data is monitored through the quality performance dashboard:
  Quarter 1 58%,
  Quarter 2 73%
  Quarter 3 85%
  This improvement throughout the year demonstrates that the target of 95% compliance at the end of Quarter 4 is achievable.

- Reduce Harm to patients particularly in relation to newly formed pressure ulcers
  Grade 3 pressure ulcers
  Grade 4 pressure ulcers
  Hospital acquired, avoidable grade 2 pressure ulcers

WUTH has consistently achieved its harm free target of > 95% during 2018. “Old” pressure ulcers are predominately the main prevalence reason for harm within the safety thermometer audit.
Work is underway to monitor hospital acquired pressure ulcer prevalence via the performance quality dashboard.

2019/ 2020 proposed priority

- The assessment of VTE and bleeding for a patient, as soon as possible after admission to hospital, is recommended by NICE. The assessment should utilise a national assessment tool and lead to the prevention of VTE. This is a key safety measure and is a priority for the Trust. A work stream is underway with a trajectory for full compliance. This work stream is maximizing our use of Wirral Millennium.

- The reduction of inappropriate bed moves for patients with dementia should have a positive impact on harm to this patient group. There has been positive progress in reducing inappropriate bed moves (moves where there isn’t a clinical indication for the patient with dementia to move). A review of bed moves of patients with Dementia has shown that this cohort of patients is of particular risk of this occurring when hospital capacity is high.

- The safety of patients who are cared for in non-ward areas when the hospital is under bed pressures. When all beds have been utilised including specialty beds and escalation beds in ED, any empty ward/area may be considered for use if it can be staffed safely, with experienced staff and with the appropriate skill mix. Patient safety, dignity and privacy are paramount and it is crucial that environmental facilities and amenities are in place prior to the transfer of patients to this area. Monitoring of compliance with the arrangements set out within the Trusts ‘Escalation Policy’ provides assurance that the safety, privacy and dignity of our patients is being maintained.

4. Next Steps

The council of governors is asked to review the above metrics for local priority improvement and select one for inclusion in the 2019/20 quality account.

5. Conclusion

The local improvements options suggested for 2019/20 are related to risks when there are capacity pressures within our hospital. These recommendations follow on from quality improvement work undertaken in 2018/2019 relating to safe discharge and appropriate flow of patients through the hospital.

6. Recommendations

The council of governors is asked to consider the above information and agree a local priority quality improvements indicator for 2019/20.

BOARD OF DIRECTORS	
Agenda Item	9.1.1
Title of Report	Quality and Performance Dashboard
Date of Meeting	30th January 2019
Author	WUTH Information Team and Governance Support Unit
Accountable Executive	COO, MD, CN, DQG, HRD, DoF
BAF References **Strategic Objective** **Key Measure** **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance **Positive** **Gap(s)**	Gaps in Assurance
Purpose of the Paper **Discussion** **Approval** **To Note**	Provided for assurance to the Board
Reviewed by Assurance Committee	None. Publication has coincided with the meeting of the Board of Directors.
Data Quality Rating	TBC
FOI status	Unrestricted
Equality Impact Assessment Undertaken **Yes** **No**	No adverse equality impact identified.

1. Executive Summary

This report provides a summary of the Trust's performance against agreed key quality and performance indicators. The Board of Directors is asked to note performance to the end of December 2018.

2. Background

This Quality and Performance Dashboard is designed to provide an accessible oversight of the Trust's performance against key indicators. The additional exception report provides a summary of the remedial action being undertaken where indicators are not meeting the established targets or thresholds for the standards.

The Quality & Performance Dashboard is work-in-progress and will develop further iterations over time. This will include development of targets and thresholds where these are not currently established and the sourcing of data where new indicators are under development.

3. Key Issues

Of the 58 indicators with established targets that are reported for December:

- 34 are currently off-target or failing to meet performance thresholds
- 24 of the indicators are on-target

The metrics included are under review with the appropriate Director to consider the appropriateness and value of inclusion, and also the performance thresholds being applied. A revised version of metrics and performance will be included in future reports to the Board of Directors, as the changes to metrics are approved.

Also under consideration are the criteria for requiring an exception report, or Issue, Decision, Action (IDA) summary. The previous approach has been to include IDA summaries for all metrics that are 'Red' for the most recent month, excluding the Use of Resources metrics as there is a separate financial report to the BoD.

This can result in a lot of exceptions being reported repeatedly for metrics that are continually not at threshold, but not materially changing. The proposed criteria for requiring an IDA summary from now on is any metric that newly fails its threshold for two consecutive months. The initial IDA also now requires an expected date of achievement of threshold. If a metric does not achieve by that expected date, an updated IDA summary would also be required.

And to provide assurance on all performance measures not achieving threshold, on a quarterly basis all metrics that have been 'Red' for the preceding six months would require an updated IDA summary. The next quarterly IDA summaries on such metrics will be in April 2019, on performance up to and including March.

On this criteria, the only metric this month requiring an IDA summary is "Diagnostic Waiters, 6 weeks and Over".

4. Next Steps

WUTH remains committed to attaining standards through 2018-19.

5. Conclusion

Performance against many of the indicators is not where the Trust needs to be. The actions to improve are noted in the exceptions on the qualifying metrics and this report in future will provide monitoring and assurance on progress.

6. Recommendation

The Board of Directors is asked to note the Trust's current performance against the indicators to the end of December 2018.

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	13 month Trend	In-year 2018/19 Trajectory
Safe	Falls per 1000 occupied bed days reported on Ulysses (excluding lowered to floor incident)	Safe, high quality care	DoN	≤4.8 per 1000 Bed Days	WUTH	1.40	1.30	1.50	1.30	1.90	2.20	1.50	2.00	2.30	1.20	1.75	1.11	1.78	1.75		
	Eligible patients having VTE risk assessment within 6 hours of decision to admit.	Safe, high quality care	MD	≥95%	WUTH	64.3%	58.7%	69.2%	60.1%	65.0%	70.4%	76.9%	81.5%	69.2%	75.0%	77.0%	68.9%	78.9%	73.6%		
	Percentage of adult patients admitted who were assessed for risk of VTE on admission to hospital.	Safe, high quality care	MD	≥95%	SOF	95.4%	95.3%	95.6%	95.2%	95.3%	95.3%	94.7%	95.3%	95.0%	95.6%	95.6%	95.6%	95.2%	95.3%		
	Harm Free Care Score (Safety Thermometer)	Safe, high quality care	DoN	≥95%	National	94.3%	97.0%	95.0%	96.0%	95.6%	95.6%	95.4%	95.2%	95.0%	96.3%	97.0%	95.9%	95.3%	95.7%		
	Serious Incidents declared	Safe, high quality care	DQ&G	≤48 pa (= 4 per month)	WUTH	11	6	10	6	6	14	13	3	2	1	3	2	4	48		
	Never Events	Safe, high quality care	DQ&G	0	SOF	0	0	1	0	0	0	0	1	0	0	0	0	0	1		
	CAS Alerts not completed by deadline	Safe, high quality care	DQ&G	0	SOF	1	1	3	0	0	1	5	1	0	0	0	0	0	7		
	Clostridium Difficile (avoidable)	Safe, high quality care	DoN	≤28 for FY18-19, 2.42 per month	SOF	2	1	1	3	4	1	3	1	3	0	3	4	2	21		A M J J A S O N D J F M
	E.Coli infections	Safe, high quality care	DoN	≤42 pa (No more than 3 per month)	WUTH	2	4	1	2	4	2	6	7	2	3	5	4	2	35		
	CPE Colonisations/Infections	Safe, high quality care	DoN	TBC	WUTH	20	16	13	10	11	14	17	18	18	15	13	23	9	138		
	MRSA bacteraemia - hospital acquired	Safe, high quality care	DoN	0	National	0	0	0	1	0	0	0	0	0	0	0	1	0	1		
	IPC Audit of Practices and Procedures (random areas)	Safe, high quality care	DoN	≥75% (gold)	WUTH	77%	73%	73%	78%	83%	81%	78%	77%	78%	74%	75%	75%	76%	77%		
	Hand Hygiene Compliance	Safe, high quality care	DoN	100%	WUTH	94%	89%	94%	99%	95%	97%	88%	89%	90%	81%	87.0%	85.0%	76.0%	87.6%		
	Medicines Storage audits - % of areas fully compliant	Safe, high quality care	DoN	100%	WUTH	-	52%	51%	52%	57%	70%	69%	71%	74%	72%	73%	60%	78%	69.3%		
	Surgical Site Infections (data once per year over 3 months)	Safe, high quality care	DoN	TBC	WUTH	Indicator Under development															
	Surgical Safety Checklist Compliance	Safe, high quality care	MD	100%	WUTH	Indicator Under development															
	Protecting Vulnerable People Training - % compliant (Level 1)	Safe, high quality care	DoN	≥95%	WUTH	90.9%	90.6%	89.9%	89.5%	89.2%	-	-	87.4%	-	85.6%	90.4%	91.5%	91.4%	89.2%		
	Protecting Vulnerable People Training - % compliant (Level 2)	Safe, high quality care	DoN	≥95%	WUTH	81.1%	81.3%	80.7%	82.5%	84.8%	-	-	82.7%	-	82.2%	86.0%	87.2%	87.1%	85.0%		
	Protecting Vulnerable People Training - % compliant (Level 3)	Safe, high quality care	DoN	≥95%	WUTH	84.6%	83.6%	83.8%	85.2%	85.6%	-	-	85.6%	-	86.5%	87.2%	91.7%	91.4%	88.0%		
	Nursing Vacancy Rate	Safe, high quality care	DHR	≤6.5%	WUTH	6.09%	6.50%	6.89%	6.83%	6.57%	7.11%	7.20%	10.24%	10.20%	9.25%	7.90%	7.90%	7.47%	7.47%		
	Consultant Vacancy Rate %	Safe, high quality care	DHR	≤6.5%	WUTH	7.75%	7.47%	8.26%	9.68%	6.95%	6.93%	6.58%	7.62%	6.87%	6.45%	6.88%	7.90%	6.48%	6.48%		
	Sickness absence % (12-month rolling average)	Safe, high quality care	DHR	≤4%	SOF	4.61%	4.69%	4.71%	4.77%	4.78%	4.82%	4.84%	4.84%	4.87%	4.91%	4.94%	4.93%	4.94%	4.80%		
	Short-term sickness (in month rate)	Safe, high quality care	DHR	TBC	WUTH	1.92%	2.42%	2.19%	2.20%	1.79%	2.04%	2.04%	2.03%	2.24%	2.35%	2.43%	2.19%	2.36%	2.16%		
	Long-term sickness (in-month rate)	Safe, high quality care	DHR	TBC	WUTH	2.88%	2.97%	2.10%	2.19%	2.18%	2.33%	2.65%	2.95%	2.79%	2.55%	2.76%	2.81%	3.09%	2.68%		
	Care hours per patient day (CHPPD)	Safe, high quality care	DoN	TBC	WUTH	7.1	7.1	7.2	7.1	7.2	7.3	7.4	7.6	7.5	7.1	6.9	7.1	7	-		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Effective	SHMI	Safe, high quality care	MD	≤100	SOF	94.04	-	-	99.49	-	-	97	-	-	-	-	-	-	99		
	HSMR	Safe, high quality care	MD	≤100	SOF	89.0	88.0	88.0	88.0	88.7	93.0	93.0	95	95	95	-	-	-	91		
	Mortality Reviews Completed		MD		WUTH	Indicator Under Development															
	Nutrition and Hydration - MUST completed at 7 days	Safe, high quality care	DoN	≥95%	WUTH	-	-	-	-	44%	59%	71%	78%	67%	74%	84%	87%	83%	71.9%		
	SAFER BUNDLE: % of discharges taking place before noon	Safe, high quality care	COO/ DoN	≥33%	National	15.0%	14.3%	14.8%	14.6%	14.9%	14.3%	13.9%	12.9%	14.1%	13.1%	15.4%	16.4%	14.6%	14.4%		
	SAFER BUNDLE: Average number of stranded patients at 10am (in hospital for 7 or more days) - actual	Safe, high quality care	COO/ DoN	≤156	WUTH	369	412	417	422	418	405	341	386	387	411	383	408	397	393		
	SAFER BUNDLE: Expected date of discharge achieved	Safe, high quality care	COO/ DoN	TBC	WUTH	-	-	-	-	-	-	-	-	-	-	-	-	-	-		
	Length of stay - elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.0	3.9	7.4	4.0	3.8	4.3	3.8	5.2	4.1	4.2	4.3	3.8	4.9	4.3		
	Length of stay - non elective (actual in month)	Safe, high quality care	COO	TBC	WUTH	5.2	5.1	5.2	5.4	5.1	5.2	5.1	5.4	5.0	4.9	5.3	5.1	5.0	5.1		
	Emergency readmissions within 28 days	Safe, high quality care	COO	TBC	WUTH	891	849	840	814	886	923	873	913	961	888	936	925	917	914		
	Delayed Transfers of Care	Safe, high quality care	COO	TBC	WUTH	14	11	12	9	13	12	13	13	6	18	12	17	14	11.4		
	NICE Guidance Compliance (Assessment & Gap Analysis)	Safe, high quality care	DQ&G	100%	WUTH	-	-	71.0%	72.0%	72.0%	73.0%	73.0%	73.0%	73.0%	74.0%	74.0%	98.0%	98.0%	98%		
	% of national clinical audits participation / % required	Safe, high quality care	DQ&G	100%	National	-	-	-	-	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	87.5%	95.0%	95.0%	95.0%		
	% Theatre Utilisation	Safe, high quality care	COO	≥85%	WUTH	82.9%	78.3%	79.1%	79.8%	85.9%	86.6%	88.6%	86.7%	92.3%	89.2%	88.9%	87.1%	86.0%	87.9%		

Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Caring	Same sex accommodation breaches	Outstanding Patient Experience	DoN	0	SOF	16	12	18	16	18	22	10	8	16	14	19	18	15	140		
	FFT Recommend Rate: ED	Outstanding Patient Experience	DoN	≥95%	SOF	88%	92%	87%	82%	85%	90%	91%	89%	89%	86%	87%	84%	92%	88%		
	FFT Overall Response Rate: ED	Outstanding Patient Experience	DoN	≥25%	WUTH	11.0%	12.0%	13.0%	12.0%	13.0%	9.0%	8.0%	11.0%	12.0%	11.0%	10.0%	11.0%	10.0%	11%		
	FFT Recommend Rate: Inpatients	Outstanding Patient Experience	DoN	≥95%	SOF	98%	98%	97%	97%	98%	97%	98%	98%	98%	97%	98%	98%	98%	98%		
	FFT Overall response rate: Inpatients	Outstanding Patient Experience	DoN	≥25%	WUTH	17.0%	15.0%	18.0%	18.0%	15.0%	15.0%	20.0%	25.0%	14.0%	22.4%	24.0%	18.0%	18.0%	19%		
	FFT Recommend Rate: Outpatients	Outstanding Patient Experience	DoN	≥95%	SOF	95%	95%	94%	94%	95%	95%	94%	95%	94%	94%	94%	95%	94%	94%		
	FFT Recommend Rate: Maternity	Outstanding Patient Experience	DoN	≥95%	SOF	93%	97%	98%	100%	97%	97%	99%	96%	100%	100%	96%	100%	100%	98%		
	FFT Overall response rate: Maternity (point 2)	Outstanding Patient Experience	DoN	≥25%	WUTH	30%	15%	54%	35%	31%	54%	46.0%	37.0%	17.0%	28.2%	11.0%	19.0%	37.0%	31%		

Quality Performance Dashboard

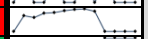
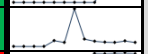
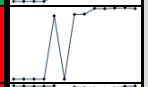
January 2019

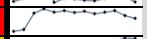
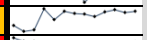
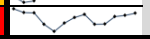
	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Responsive	4-hour Accident and Emergency Target (including Arrowe Park All Day Health Centre)	Safe, high quality care	COO	≥95%	SOF	78.4%	78.5%	78.3%	74.4%	80.3%	83.5%	83.4%	85.6%	83.6%	77.8%	77.8%	75.2%	75.0%	80.2%		A M J J A S O N D J F M
	Patients waiting longer than 12 hours in ED from a decision to admit.	Outstanding Patient Experience	COO	0	National	0	0	0	0	0	0	0	0	0	0	0	0	0	0		
	Ambulance Handovers >30 minutes	Safe, high quality care	COO	TBC	National	651	528	427	623	414	327	291	213	326	474	371	440	393	361		
	Patients leaving ED without being seen	Outstanding Patient Experience	COO	<=5%	WUTH	3.9%	2.3%	3.0%	4.3%	2.8%	2.8%	1.4%	1.7%	1.5%	2.3%	2.2%	2.0%	2.3%	2.1%		
	18 week Referral to Treatment - Incomplete pathways < 18 Weeks	Safe, high quality care	COO	≥92%	SOF	77.7%	76.4%	75.6%	77.3%	74.3%	74.6%	75.7%	76.3%	77.2%	78.3%	78.98%	79.34%	80.08%	77.2%		A M J J A S O N D J F M
	Referral to Treatment - cases exceeding 52 weeks	Safe, high quality care	COO	0	National	11	30	51	69	66	67	79	57	56	40	43	30	28	52		A M J J A S O N D J F M
	Diagnostic Waiters, 6 weeks and over - DM01	Safe, high quality care	COO	≥99%	SOF	98.7%	98.8%	99.2%	99.2%	99.0%	98.2%	97.9%	98.5%	97.9%	99.2%	99.4%	98.9%	98.6%	98.6%		
	Cancer Waiting Times - 2 week referrals	Safe, high quality care	COO	≥93%	National	97.4%	97.0%	96.9%	94.9%	94.2%	93.4%	95.2%	95.7%	92.3%	94.5%	95.2%	93.9%	93.2%	94.2%		
	Cancer Waiting Times - % receiving first definitive treatment within 1 month of diagnosis	Safe, high quality care	COO	≥96%	National	97.0%	97.0%	99.1%	97.0%	96.5%	96.4%	95.5%	98.2%	96.3%	96.2%	96.8%	96.7%	97.3%	96.6%		
	Cancer Waiting Times - 62 days to treatment	Safe, high quality care	COO	≥85%	SOF	85.9%	85.8%	86.4%	88.1%	87.0%	86.1%	87.8%	85.4%	87.9%	85.7%	85.1%	85.3%	93.0%	87.0%		
	Cancelled outpatient appointments	Outstanding Patient Experience	COO	TBC	WUTH	5304	6437	5808	3451	6131	6035	6515	6862	6771	6183	7098	6641	5728	57964		
	Cancelled elective admissions - TCIs	Outstanding Patient Experience	COO	TBC	WUTH	316	711	307	345	206	190	243	218	234	203	266	277	174	2011		
	Cancelled Operations (on the day of planned surgery)	Outstanding Patient Experience	COO	TBC	WUTH	30	12	27	20	9	26	15	8	2	7	7	17	11	102		
	Did Not Attend - Outpatient Appointments	Outstanding Patient Experience	COO	≤6.5%	WUTH	9.1%	8.6%	8.0%	8.1%	8.3%	8.6%	8.2%	8.7%	8.9%	8.7%	8.3%	8.4%	8.6%	8.5%		
	Appointment slot issues (Outpatient Utilisation)	Outstanding Patient Experience	COO	TBC	WUTH	1730	1532	1703	1812	2325	2477	3646	3868	4076	4117	4383	5075	5285	3917		
	Patient Experience: Number of concerns received in month - Level 1	Outstanding Patient Experience	DoN	TBC	WUTH	68	123	134	144	118	134	110	140	123	155	119	165	118	1182		
	Patient Experience: Number of complaints received in month - Levels 2 to 4	Outstanding Patient Experience	DoN	TBC	WUTH	21	43	31	30	34	23	36	24	25	22	19	13	13	209		
	Complaint acknowledged within 3 working days	Outstanding Patient Experience	DoN	100%	National	100%	96%	100%	97%	32%	81%	95%	72%	75%	80%	100%	100%	100%	81.6%		
	First written response within policy timescale	Outstanding Patient Experience	DoN	100%	WUTH	50%	19%	35%	22%	14%	32%	23%	23%	11%	29%	48%	39%	41%	29.0%		
	Number of re-opened complaints	Outstanding Patient Experience	DoN	≤5 pcm	WUTH	6	4	4	1	2	2	7	5	0	4	2	3	2	27		

Appendix 1
Wirral University Teaching Hospital NHS Foundation Trust

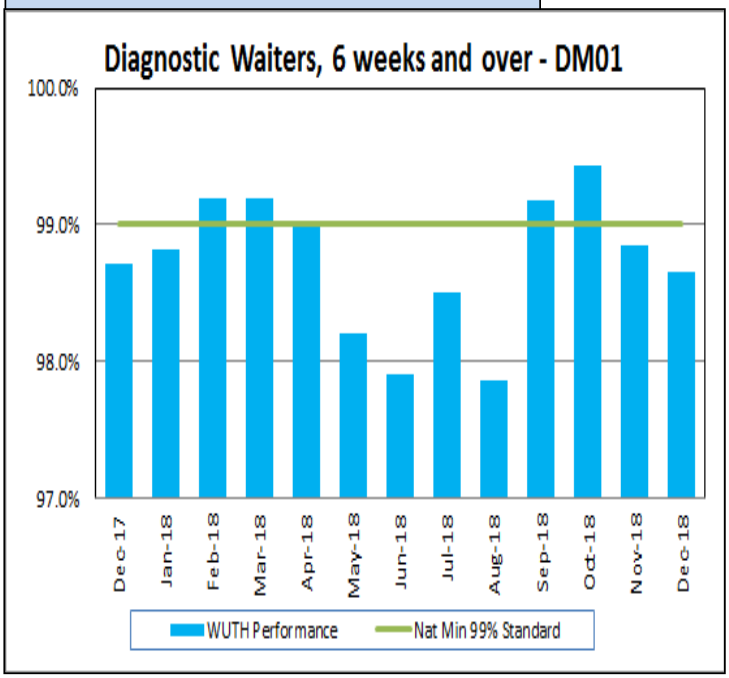
Quality Performance Dashboard

January 2019

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Well-led	Staff Friends and Family Test - overall engagement score	Safe, high quality care	DHR	≥3.88	National	–	3.75	–	–	3.60	–	–	3.72	–	3.63	–	–	–	3.65		
	Live employee relations cases	Safe, high quality care	DHR	≤30	WUTH	–	25	22	29	30	33	35	36	32	29	23	30	32	33		
	Duty of Candour compliance (for all moderate and above incidents)	Outstanding Patient Experience	DQ&G	100%	National	–	–	–	–	–	–	–	–	–	100%	100%	100%	100%	100.0%		
	Number of patients recruited to NIHR research studies	Outstanding Patient Experience	MD	650 for FY18/19 (= average 55 per month)	National	–	–	–	–	53.00	37.00	334.00	66.00	46.00	40.00	35.00	50.00	36.00	697		
	% Mandatory Training compliance	Safe, high quality care	DHR	≥95%	WUTH	–	–	–	have	73.0%	–	74.8%	75.1%	82.0%	81.4%	82.2%	82.8%	81.5%	81.5%		
	% Appraisal compliance	Safe, high quality care	DHR	≥88%	WUTH	85.5%	84.3%	83.4%	83.3%	84.9%	–	81.1%	79.7%	78.2%	77.5%	78.4%	83.8%	84.5%	84.5%		

	Indicator	Objective	Director	Threshold	Set by	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	18/19 YTD	Trend	In-year 2018/19 Trajectory
Use of Resources	I&E Performance		DoF	On Plan	WUTH	-3.712	-2.315	-1.614	6.485	-4.259	-2.337	-2.659	-3.139	-3.426	-2.334	-1.246	-1.445	-4.038	-24.883		
	I&E Performance (Variance to Plan)		DoF	On Plan	WUTH	-2.898	-2.624	-0.424	0.162	-0.296	-0.103	-0.340	-0.184	-0.515	-0.319	-0.121	-0.761	-1.127	-3.766		
	NHSI Risk Rating		DoF	On Plan	NHSI	3	3	3	3	3	3	3	3	3	3	3	3	3	3		
	CIP Forecast		DoF	On Plan	WUTH	-38.4%	-41.6%	-44.0%	-43.8%	-34.1%	-36.3%	-27.2%	-22.1%	-15.4%	-11.7%	-10.6%	-5.4%	-6.1%	-6.1%		
	NHSI Agency Ceiling Performance		DoF	NHSI cap	NHSI	19.6%	4.3%	15.7%	21.8%	17.8%	1.1%	20.7%	-28.8%	-5.4%	8.7%	-11.1%	-7.4%	-0.5%	-0.5%		
	Cash - liquidity days		DoF	NHSI metric	WUTH	-17.5	-19.6	-19	-11.7	-15.5	-12.5	-13.3	-13.5	-14.4	-12.7	-12.0	-13.0	-12.5	-12.5		
	Capital Programme		DoF	On Plan	WUTH	68.6%	53.1%	51.2%	3.9%	-25.3%	9.8%	32.9%	45.0%	4.9%	5.2%	35.8%	41.4%	50.3%	50.3%		

Diagnostic Waiters, 6 weeks and over - DM01



Executive Lead: Chief Operating Officer

Issue: The trust has a target of a minimum 99% of patients awaiting diagnostic tests to be within 6 weeks. This has not been achieved for the last two months, and 2018/19 YTD performance is 98.6%.

Decision: Capacity in two key modalities is not resilient enough.

Action: Departments in the two key areas of echocardiography and urodynamic CMGs are working on recovery trajectories to reduce the number of patients waiting that breach this standard.

Expected Month Threshold to be Achieved:
February 2019

Wirral University Teaching Hospital NHS Foundation Trust

Board of Directors	
Agenda Item	10.8
Title of Report	CQC Action Plan progress Update
Date of Meeting	30 January 2019
Author	Paul Moore, Director of Quality & Governance
Accountable Executive	Janelle Holmes, Chief Executive
BAF References • **Strategic Objective** • **Key Measure** • **Principal Risk**	Quality and Safety of Care Patient flow management during periods of high demand
Level of Assurance • **Positive** • **Gap(s)**	To be confirmed.
Purpose of the Paper • **Discussion** • **Approval** • **To Note**	For Discussion
Data Quality Rating	Bronze - qualitative data
FOI status	Document may be disclosed in full
Equality Impact Assessment Undertaken • **Yes** • **No**	No

CQC ACTION PLAN UPDATE REPORT
POSITION AS AT 19TH JANUARY, 2019

1. PURPOSE

1.1 The purpose of this report is to update on the progress of the CQC Action Plan, and to highlight, by exception, any elements of the plan that are not on track or at risk of not meeting target dates for implementation. This report also provides assurance on those actions that have been embedded (completed and sustained for a period of 3 months or more).

2. BACKGROUND OR CONTEXT

2.1 The CQC Action Plan brings together the actions required to address the CQC compliance concerns identified following inspection in March 2018. The plan takes account of: (i) all the 'must do' and should do' recommendations contained within the inspection reports; and (ii) some improvement interventions identified locally as immediate quality priorities by the Trust. After sufficient progress has been made the plan will evolve to incorporate matters highlighted as high risk within the Quality & Risk Profile for WUTH, and develop into the tactical plan to drive and deliver the Trust's Quality Strategy.

2.2 The CQC Action Plan has implications for NHS Improvement's enforcement undertakings and, in this regard, the Board is committed demonstrating, no later than August 2019, that: (i) it has addressed all the 'must do' and 'should do' recommendations to the CQC, NHSI and CCG satisfaction; (ii) is no longer considered by CQC to be inadequate in the well-led domain; and (iii) has improved against all CQC domains rated as inadequate or requires improvement when compared to the CQC's inspection findings.

3. ANALYSIS

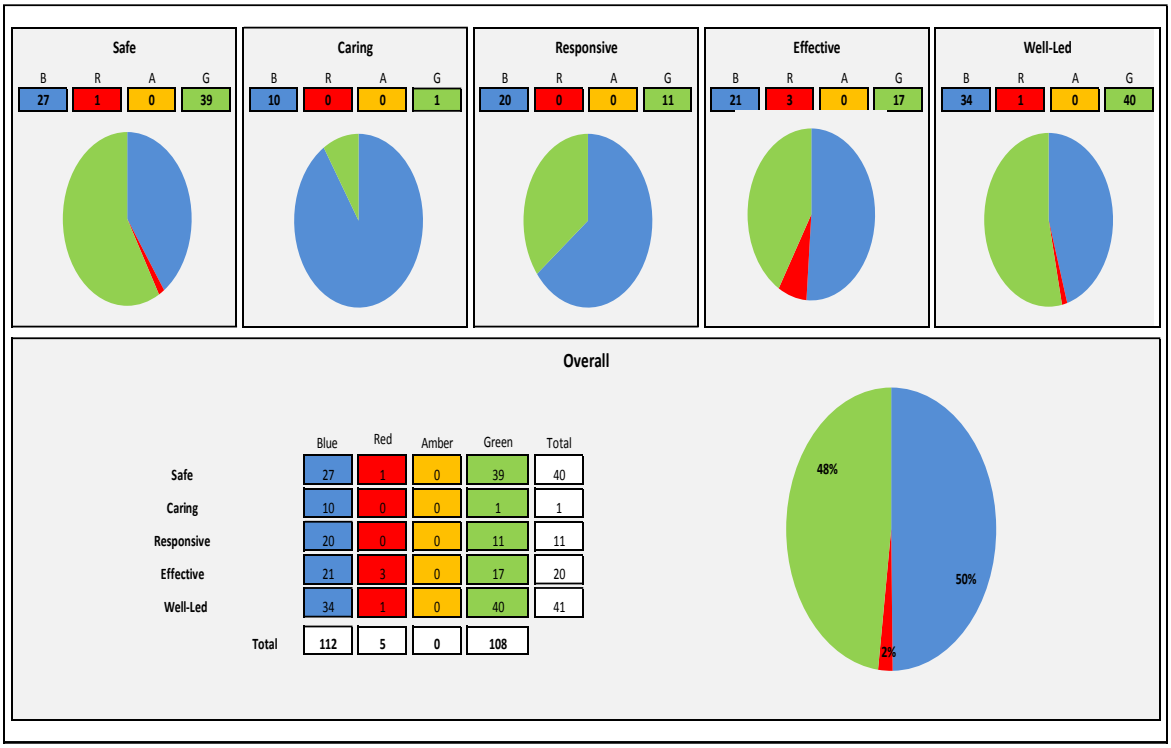
3.1 The CQC inspected the Trust in March and May 2018. The outcome of the inspection was as follows:

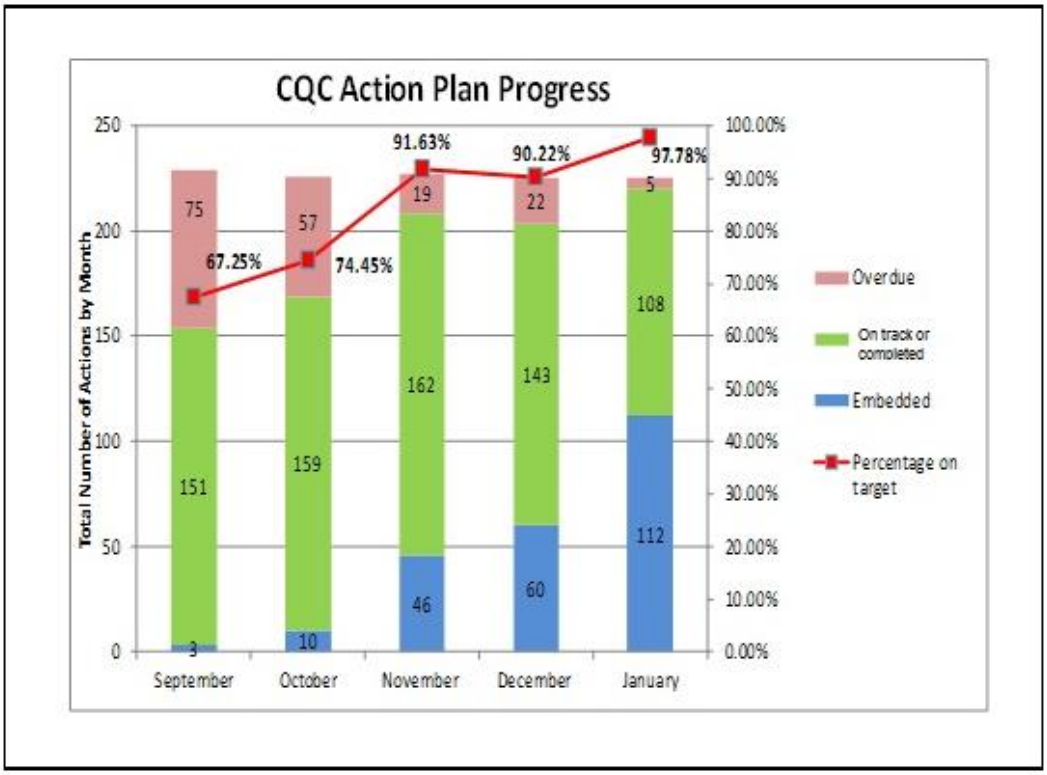
Safe	Requires improvement	
Effective	Requires improvement	
Caring	Good	
Responsive	Requires improvement	
Well Led	Inadequate	
OVERALL	REQUIRES IMPROVEMENT	

The Trust has developed a quality improvement action plan to address all concerns identified by the CQC. The quality improvement action plan has **225** specific actions/work-plans for implementation by **(31st March 2019).**

The delivery of the quality improvement action plan is reviewed monthly and performance is reported through to the Board at each formal meeting.

4. CQC Action Plan Progress – January 2019





5. EXCEPTIONS

Following the *Confirm and Challenge* meetings held week commencing 7th January 2019, there are 5 actions which have been 'red-rated' and are to be reported as exceptions for this reporting period. As expected we have seen an encouraging improvement from December's reported position.

Overdue actions concern operational matters and refer to medicines storage, risk reporting tools, Pain Management & ED Assessment protocols and Clinical issues in regards to MEWS system upgrade, which is an external issue. For reference the detail of overdue actions is set out in **Annex A**.

In **Annex B** we draw the Board's attention to 'embedded' actions (i.e. those actions completed and sustained for 3 months or more). In line with expectations set out in the plan, the number of embedded actions has increased significantly in this reporting period with 52 actions moving into the embedded category. This can be interpreted by the Board as positive evidence of implementation, and the progressive work that is happening across the Trust to address each element of the action plan.

6. POTENTIAL IMPLICATIONS (of failing to deliver the plan)

Risks (associated with failing to deliver the CQC action plan) include:

I. Service users are exposed to unacceptable levels of harm arising from inadequate compliance with CQC fundamental standards of care;
II. The Trust fails to comply with CQC Registration Regulations and has it's Certification of Registration revoked; and/or
III. A failure to resolve basic compliance concerns in respect of CQC regulations leads to further NHSI enforcement undertakings and compromise the Trust's Provider Licence.

The CQC Action Plan provides the means of improving control over these risks alongside the Trust pre-existing organisational control framework.

7. NEXT STEPS

The report will be presented at the next Board meeting.

ANNEX A

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
167	Must Do	Corporate / Trust-Wide Issues	"RISK REGISTER This issue affects all divisions but the report highlighted the Critical Care, Medicine and End of Life Care core services Critical Care : The provider must ensure that where risks are identified, measures are taken to reduce or remove the risks with a timescale that reflects the level of risk and impact on people using the service. Medicine : The service should ensure that all identified risks are placed on the risk register and that they are regularly reviewed and action implemented in a timely way. End of Life Care : The service should review the way their risks are recorded so there is a record of them in one place which corresponds to those on the divisional risk registers.	Review and refresh the divisional risk profile	Executive Director of Quality & Governance	Well Led	**UPDATED 15.01.2019** – Delayed due to sustained operational pressures across divisional triumvirates. All divisions have confirmed the actions they are taking to refresh and re-populate divisional-level risk register. This work is progressing, but not at the pace required. Awaiting receipt of Divisional risk registers. Expected to be received by Monday 21st January 19. Recovery anticipated in February. Output will be used to refresh the Corporate Risk Register and Board Assurance Framework	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
190	Should Do	Medical Care (Acute & Medical Division)	**"MEDICINES STORAGE** The service should ensure the safe and proper storage of medicines on the wards. "	Rectify defects identified through the existing quarterly audits in all wards and departments	Executive Medical Director	Effective	**Updated: 16/01/2019** Progress in this area is unsatisfactory; compliance with medicines storage deteriorated in December 2018. Additional Confirm & Challenge meetings took place with Director of Pharmacy to escalate compliance concerns and secure the assurances needed to demonstrate progress against this action. It has been highlighted that the current audit used to demonstrate compliance is very detailed and burdensome. There is opportunity to simplify and rationalise the assessment to assist colleagues to comply and the Director of Pharmacy has taken steps in this direction. We are focussing on simplifying the audit process and driving accountability at ward-level for compliance. A review will take place in early February. The Quality Committee will scrutinise the position on the Board's behalf at their meeting to be held on January 2019.	01/11/2018	
111	Should do	Urgent And Emergency Care (Acute & Medical Division)	**Pain Management** The service should ensure that pain management is recorded appropriately and that pain relief is administered in a timely manner when needed.	Review and provide assurance on the adequacy of pain management training and completion to PSQB	Executive Director of Nursing and Midwifery	Effective	**Updated: 08/01/2019** On line training packages are now available to staff Compliance and adoption rates of these training cannot as yet be evidenced. A review is underway with Pain Management Leadsto considered including pain management training as part of the 'role specific/ essential training programme'.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream	Progress	Due Date	RAG
208	Must Do	Urgent And Emergency Care (Acute & Medical Division)	**INITIAL ASSESSMENT** The service must ensure that patients receive an initial assessment within 15 minutes of arrival, in line with trust policy and Royal College of Emergency Medicine standards.	Ensure practice within ED adheres to Trust policy – all patients to be assessed within 15 minutes of booking in – by reinforcing existing Standard Operating Procedures (1/8/18)	Chief Operating Officer	Effective	**Updated: 10/01/2019** The Trust can demonstrate that it is documenting and reporting against standard; however, it is not yet able to demonstrate compliance with national standards. Investment has been made to increase nursing capacity in ED. Performance is reported daily via ED dashboard and monitored through Patient Flow Improvement Group (PFIG). A review will be undertaken of the current triage system.	01/09/2018	

210	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**mews SCORES** The service should ensure that patients who have an increased modified early warning score are monitored and escalated for further review, in line with trust policy.	Review and develop the policy for recognising and responding to the signs of clinical deterioration (to incorporate the requirement to implement NEWS2)	Executive Medical Director, Executive Director of Nursing and Midwifery	Safe	**Updated: 15/01/2019** Implementation of NEWS2 has commenced but an unanticipated technical issue with the Trust's Wirral Millennium (Cerner) system will require addressing before any further progress can be made. Subject to the response from Cerner, implementation of NEWS2 may be delayed. This matter has been escalated internally and with the system vendor.	01/11/2018	

ANNEX B (Embedded actions in January 2019)

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
13 (1)	Should Do	Corporate / Trust-Wide Issues	**PERFORMANCE REPORTING** **Trust wide :** The trust should ensure that divisional review of performance is undertaken effectively. **Emergency Department :** The service must ensure that there are effective systems in place to monitor the service provided and that when areas for improvement are identified, actions to make improvements are completed in a timely manner.	Design a consistent divisional dashboard that ensures review of all performance (operational and financial) metrics	Chief Operating Officer	Well Led	**UPDATED 10/01/2019 -** Embedded process. Divisional dashboards are produced monthly.	01/11/2018	
14 (2)	Should Do	Corporate / Trust-Wide Issues		Implement divisional performance reporting dashboard on a monthly basis	Chief Operating Officer	Well Led	**UPDATED 10/01/2019** Evidence satisfies action and confident that this has been embedded.	31/08/2018	
16 (3)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**MAJOR INCIDENT EQUIPMENT** The service should ensure that staff are able to access major incident equipment in a timely manner and that major incident equipment is checked and maintained in line with trust policy.	Obtain assurance from ED departmental lead that the Major Incident equipment is kept secure, checked regularly and accessed by authorised personnel only	Chief Operating Officer	Safe	**UPDATED 10/01/2019** Evidence satisfies action and confident that this has been embedded.	31/08/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
17 (4)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Report assurance to the Risk Management Committee	Chief Operating Officer	Safe	**UPDATED 10/01/2019** Evidence satisfies action and confident that this has been embedded.	31/08/2018	
20 (5)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**STORAGE IN ED** The service should consider ways to make sure that all equipment in the department is stored appropriately.	Review and develop the supply chain management so that storage requirements are kept to an absolute minimum			**UPDATED 10/01/2019 -** Full review has taken place no changes are recommended	01/11/2019	
21 (6)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**MIXED SEX BREACHES** The department should consider ways to ensure that all breaches of mixed sex accommodation in the emergency department review unit are recorded appropriately.	Clarify precisely the arrangements to record mixed sex accommodation breaches in ED	Chief Operating Officer	Caring	**UPDATED 10/01/2019** - Meetings have been held with the departmental leadership team, satisfied if there was a breach it will be recorded.	01/10/2018	
22 (7)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Audit compliance to verify that breaches, where they occur, have been record properly	Chief Operating Officer	Caring	**UPDATED 10/01/2019 -** Evidence submitted confirms Trust appropriately reports mixed sex accommodation breaches.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
25 (8)	Should Do	Medical Care (Acute & Medical Division)	The service must ensure they assess the risk to health and safety of patients when accommodating patients in escalation areas and do all that is practicable to mitigate any risks. Care and treatment of patients with higher acuity must take place in appropriate areas that are safe for such use.	Provide assurance to the Risk Management Committee that all wards and departments have in place an up to date COSHH folder with relevant in date risk assessments and material safety data sheets to demonstrate compliance with COSHH regulations	Chief Operating Officer	Effective	**UPDATED 10/01/2019 -** Completed in 17th December 18. Risk Committee was satisfied with assurances provided from the health and safety manager.	01/10/2018	
30 (9)	Must Do	Corporate / Trust-Wide Issues	**HEALTH & SAFETY Surgery :** The trust must ensure systems and processes are in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users. **Emergency Department :** The service should ensure that health and safety risk assessments are kept up to date.	Carry out a site survey at APH and CBH to ensure that extension leads are compliant with all safety requirements and only PAT-tested leads are in use. A report to be provided setting out the assurance to Risk Management Committee	Chief Operating Officer	Well Led	**UPDATED 10/01/2019 -** Completed in 17th December 18. Risk Committee was satisfied with assurances provided from the health and safety manager.	01/12/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
38 (10)	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**GAS CYLINDERS** The service should ensure that storage of gas cylinders is in line with the policy and best practice.	Implement actions from pharmacy audit (Data from March 2018) that is undertaken every 2 years. All orders placed for new racking for all areas found deficient (1/11/18). The key action was to install medical gas racking, which was ordered March 2018 as a result of audit.	Chief Operating Officer	Well Led	**UPDATED 10/01/2019** CAS alert fully complied with the evidence of compliance is on the CAS system.	30/09/2018	
39 (11)	Should Do	Critical Care (Diagnostics and Clinical Support Division)	**HAND HYGIENE - SIGNS** The service should consider ensuring there are adequate signs on entry to the unit instructing visitors to wash their hands.	Include metric within Ward Accreditation reporting process that monitors and responds to hand hygiene standards	Director of Nursing	Safe	**UPDATED 08/01/2019** – Embedded process and improvement can be demonstrated via Perfect Ward app.	01/01/2019	
46 (12)	Must Do	Corporate / Trust-Wide Issues	**PERFORMANCE INFORMATION** The trust must ensure that all information that is used for managing performance is accurate and up to date. **NATIONAL GUIDANCE** The trust should ensure that compliance with national guidance is monitored.	As part of the 'Ward to Board' project, review the data set used to provide assurance and manage performance. This will clarify more directly which indicators are prioritised for use by the Board (this should be based on the Single Oversight Framework)	Director of IT and Information	Well Led	**UPDATED 08/01/2019** Embedded process and improvement can be demonstrated via Perfect Ward app	01/10/2018	
52 (13)	Must Do	Corporate / Trust-Wide Issues		Review current processes for the emergency repair and routine maintenance of equipment and develop costed plan (EBME)	Director of IT and Information	Effective	**UPDATED 08/01/2019** - A review has taken place and we are reviewing contract arrangements with suppliers.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
64 (14)	Should Do	Medical Care (Acute & Medical Division)	**HEALTH PROMOTION** The service should ensure they provide health promotion services to support national priorities to improve the population's health.	The service will reinforce the Public Health England (PHE) Evidence into Action strategy and the wider One You initiative that is already addressing the risks of: tobacco, alcohol and obesity and will harness the work on chemical and environmental risks such as UV radiation	Executive Director of Nursing & Midwifery, Executive Medical Director	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/11/2018	
65 (15)	Should Do	Medical Care (Acute & Medical Division)	**PRIVACY & DIGNITY** The service should ensure the privacy and dignity of patients is maintained at all times	The service will ensure privacy and dignity signs are provided for beds and patient areas which are designed to be attached to curtains or doors whilst care and treatment is carried out. Signs give a clear message to visitors to 'ask permission' before entering	Executive Director of Nursing & Midwifery, Executive Medical Director	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	
66 (16)	Should Do	Medical Care (Acute & Medical Division)		The service will develop a protocol for patients being treated in non-standard escalation areas so that they have arrangements put in place to maintain their privacy and dignity	Executive Director of Nursing & Midwifery, Executive Medical Director	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.		

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
67 (17)	Must Do	Corporate / Trust-Wide Issues	**COMPLAINTS** **Trust wide :** The trust must ensure that complaints are managed effectively in line with trust policy. The service should ensure that they provide information to patients and relatives so that they are aware of how to raise a concern or complaint.	Review the complaints process and amend to ensure pace is injected into the handling mechanism	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/09/2018	
68 (18)	Must Do	Corporate / Trust-Wide Issues		Clarify role and responsibilities for complaints handling at divisional and corporate levels	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	
69 (19)	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism for more robust performance management of complaints responsiveness (25-working days unless otherwise agreed with complainant)	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	
73 (20)	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism to capture and performance manage the delivery of complaint actions (this is promoting and embedding learning within front line teams)	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	
74 (21)	Must Do	Corporate / Trust-Wide Issues		The Trust will provide assurance that leaflets are available to guide people who use services on how to raise a concern or complaint	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	30/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
79 (22)	Must Do	Medical Care (Acute & Medical Division)	**NUTRITION & HYDRATION** The service must ensure patients' nutrition and hydration needs are met including supporting patients to eat and drink.	Review Nutrition and Hydration policy and procedures to ensure they are fit for purpose in all clinical areas	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Nutrition and hydration policy reviewed and approved by PSQB in November 2018	01/11/2018	
81 (23)	Must Do	Medical Care (Acute & Medical Division)		Add a metric regarding MUST compliance in the Quality Dashboard	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** MUST compliance monitored monthly - data is available and confirm and challenge meetings are underway. Challenge is to include in Quality report	01/10/2018	
82 (24)	Must Do	Medical Care (Acute & Medical Division)		Audit compliance with MUST	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019**: evidence of ongoing audits is available	01/10/2018	
83 (25)	Must Do	Medical Care (Acute & Medical Division)		Hold divisional teams to account for performance in the Divisional Performance Review meetings	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Completed, two cycles of divisional performance review where MUST indicators have been included.	01/10/2018	
84 (26)	Must Do	Medical Care (Acute & Medical Division)		Develop for each area an escalation protocol to be followed in the event of escalation being required. The protocol must set out: - Equipment required to provide care in escalated areas - Arrangements for medical review - Arrangements for the provision of food and hydration - Standards for observation - How pressure area care, privacy and dignity are to be maintained	Executive Director of Nursing & Midwifery	Caring	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
				- Provisions for medicines management and storage. - Confidentiality of medical records - Access to Cerner in escalation areas					
85 (27)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**FRIENDS AND FAMILY TEST** The service should consider ways to improve the response rate of both staff, patients and relatives in order make further improvements to the service.	Introduce electronic capture and recording of FFT responses	Deputy Director of Nursing & Midwifery, Head of Patient Experience	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	
86 (28)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Introduce text message alerts to increase response rates in ED	Deputy Director of Nursing & Midwifery, Head of Patient Experience	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded- breakdown of response rates and vehicle for review confirmed as DPR meeting.	01/10/2018	
87 (29)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Introduce text message alerts to increase response rates in ED	Deputy Director of Nursing & Midwifery, Head of Patient Experience	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded- breakdown of response rates and vehicle for review confirmed as DPR meeting.	01/10/2018	
109 (30)	Should Do	Urgent And Emergency Care (Acute & Medical Division)	**PAIN MANAGEMENT** The service should ensure that pain management is recorded appropriately and that pain relief is administered in a timely manner when needed.	Review the Pain Management Pathway and the standards for recording pain management as part of the patient pathway to be clarified	Executive Director of Nursing and Midwifery	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
110 (31)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Review the Pain Management Pathway and the standards for recording pain management as part of the patient pathway to be clarified	Executive Director of Nursing and Midwifery	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
112 (32)	Should Do	Urgent And Emergency Care (Acute & Medical Division)		Review the Pain Management Pathway and the standards for recording pain management as part of the patient pathway to be clarified	Executive Director of Nursing and Midwifery	Effective	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
114 (33)	Should Do	Medical Care (Acute & Medical Division)	**RESUSCITATION TROLLEYS** The service should ensure that all resuscitation trolleys across the service are regularly checked and emergency equipment has the appropriate portable appliance tests carried out. **Surgery :** The service should ensure any emergency equipment in areas accessible to the public without a constant staff presence should be secure.	All ward and departmental managers to provide assurance to PSQB for at least 3 months uninterrupted daily checks	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
116 (34)	Should Do	Medical Care (Acute & Medical Division)		Hold ward / departmental managers to account for delivery of daily checks at divisional performance review meeting	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
117 (35)	Should Do	Medical Care (Acute & Medical Division)		Consider introducing a managed process for restocking and sealing the trolleys	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/18	
118 (36)	Should do	Medical Care (Acute & Medical Division)		Purchase and install at least one pair of ligature cutters to be kept on the resus trolley in every area	Executive Director of Nursing and Midwifery	Responsive	**UPDATED 08/01/2019 -** Assurance submitted - signature sheet process has been put in place for monitoring and audit purposes	01/10/2018	
123 (37)	Should do	Critical Care (Diagnostics and Clinical Support Division)	**ANTT** The service should monitor and audit nursing staff carrying out aseptic non touch technique when administering medication.	Review, and where necessary, revise mandatory infection control training to enhance awareness of non-touch technique	Executive Director of Nursing and Midwifery	Safe	**UPDATED 08/01/2019 -** Assurance submitted; ANTT project plan, train the trainers rolling out in all critical care areas - phased roll out plan trust wide has been developed	01/10/2018	
125 (38)	Should do	Critical Care (Diagnostics and Clinical Support Division)		Provide assurance to PSQB that ANTT is compliant within the service	Executive Director of Nursing and Midwifery	Safe	**UPDATED 08/01/2019 -** Assurance submitted to PSQB in November 18.	01/10/2018	
136 (39)	Should Do	Medical Care (Acute & Medical Division)	**NURSING LEADERSHIP** The service should ensure there are sufficient managers at senior nurse and clinical lead level to run a service providing high quality sustainable care. **LEADERSHIP VISIBILITY** The service should improve the visibility of leaders and improve communication between staff at ward level and leaders.	Review senior nursing assurance and provide assurance to PSQB that the nursing rotas are arranged so that shifts have adequate senior nursing leadership	Divisional Director of Nursing (Acute & Medical)	Well Led	**UPDATED 08/01/2019 -** Assurance submitted to PSQB in November 18.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
153 (40)	Must Do	Corporate / Trust-Wide Issues		Introduce a mechanism to capture and performance manage the delivery of serious incident actions (this is promoting and embedding learning within front line teams).	Executive Director of Quality & Governance	Well Led	**UPDATED 08/01/2019** Satisfied PSQB is tracking the actions. Actions to be included in DPR standard suite of documentation. PL to pick up with John Halliday	01/10/2018	
172 (41)	Should Do	Maternity Services (Women's & Children's Division)	**PERFORMANCE MONITORING** The service should ensure that the performance dashboard is completed monthly for all fields and consider a review of governance roles.	Establish monthly performance review of Women's and Children's division	Executive Director of Quality & Governance	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/11/2018	
180 (42)	Should Do	Corporate / Trust-Wide Issues	**CULTURE** The trust should ensure that culture within the trust is improved.	Monitor progress via the Workforce Assurance Committee against identified measures of success	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/11/2018	
182 (43)	Should Do	Corporate / Trust-Wide Issues	**STAFFING ISSUES** The trust should consider how there is a trust oversight of all staffing issues.	Review existing management information relating to staffing issues reported to Board and committees to ensure that there is appropriate visibility of relevant indicators	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	01/11/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
183 (44)	Should Do	Corporate / Trust-Wide Issues	**STAFFING ISSUES** The trust should consider how there is a trust oversight of all staffing issues.	Implement monthly reporting of staff indicators within the divisional dashboards	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded		
184 (45)	Should Do	Corporate / Trust-Wide Issues	**RAISING CONCERNS** **Emergency Department :** The service should ensure that staff are able to raise concerns when needed and that they are acted on in a timely manner. **Medicine :** The service should ensure that staff feel valued and supported and they are able to speak up and are listened to when they do so.	Relaunch and raise the profile of the FTSU Guardian and how staff can access them	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded. Relaunch of programme has taken place		
185 (46)	Should Do	Corporate / Trust-Wide Issues		Review the mechanism for providing assurance to the Board on concerns raised with the FTSU Guardians to confirm that it is effective and sufficient to meet the Board's assurance needs	Executive Director of Workforce	Well Led	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	31/10/2018	
188 (47)	Should Do	Corporate / Trust-Wide Issues		Consider the appropriate level and benefit of the Trust's participation in the Academic Health Sciences Network, and Collaboration for Leadership in Applied Health Research and Care (CLAHRC), and whether to work more closely with TrustTech	Effective	Executive Medical Director	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	01/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
189 (48)	Should Do	Corporate / Trust-Wide Issues		Increase and promote participation in research	Effective	Executive Medical Director	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	01/11/2018	
200 (49)	Should Do	End of life Care (Acute & Medical Division)	**DEATH CERTIFICATION** The service should ensure that the issue with the timely completion of medical cause of death certificates is recorded and monitored via the relevant risk register.	Review and develop processes for ensuring timely and accurate death certification	Executive Medical Director	Responsive	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	31/10/2018	
201 (50)	Must Do	Corporate / Trust-Wide Issues	**SAFE STAFFING** **Emergency Department :** The service must ensure that appropriate numbers of nursing and medical staff are available at all times. **Medicine :** The service must deploy sufficient staff with the appropriate skills on wards and on the acute medical unit, medical short stay ward and ambulatory care unit **Surgery :** The trust must ensure there are enough staff with the right qualifications, skills, training and experience to keep people safe from avoidable harm and abuse and to provide the right care and treatment.	Include metric within Ward Accreditation reporting process that monitors and responds to national safe staffing standards	Executive Medical Director, Director of Nursing & Midwifery.	Safe	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded.	31/10/2018	

No	Must/ Should do	Dept	CQC recommendation/action	APH action	Director	Workstream,	Progress	Due Date	RAG
202 (51)	Must Do	Corporate / Trust-Wide Issues		Develop systems allowing staff to be reallocated to areas of high acuity and staff shortage	Executive Medical Director, Director of Nursing & Midwifery.	Safe	**UPDATED 08/01/2019** Evidence satisfies action and confident that this has been embedded	31/10/2018	
209 (52)	Must Do	Urgent And Emergency Care (Acute & Medical Division)		Establish a clinical audit of 15 minute assessment standards within ED	Chief Operating Officer	Effective	**UPDATED 08/01/2019** Dashboard and ED reporting metrics agreed as evidence	01/11/2018	

BOARD OF DIRECTORS

MINUTES OF PUBLIC MEETING

28 NOVEMBER 2018

BOARDROOM EDUCATION CENTRE ARROWE PARK HOSPITAL

Present

Sir David Henshaw	Interim Chair
Janelle Holmes	Chief Executive
Chris Clarkson	Non-Executive Director
Jayne Coulson	Non-Executive Director
Graham Hollick	Non-Executive Director
David Jago	Director of Finance
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery
John Coakley	Non-Executive Director
Helen Marks	Director of Workforce
Steve Igoe	Non-Executive Director

In attendance

Paul Moore	Director of Quality and Governance
Natalia Armes	Director of Transformation & Partnerships
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
Ann Taylor	Staff Governor
Jane Kearley*	Member of the Public
Joe Gibson	External Programme Assurance
Ian Wilson*	Member of the Public / Patient Story
Tracy Fennell*	Deputy Director of Nursing

Apologies

Dr King Sun Leong	Associate Medical Director, Medical & Acute
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support
Paul Charnley	Director of IT and Information

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 18-19/134	**Apologies for Absence** Noted as above.	
BM 18-19/135	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/136	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair highlighted recent local health economy discussions and the establishment of a command centre, led by WUTH to support patient flow at the front door. Agreed that each of the strategic partners is to provide an appropriate lead representative to ensure continuity	

Reference	Minute	Action
	of service during periods of increased pressure such as during the winter. If support is not forthcoming the Trust will escalate the matter to NHS England / NHS Improvement. Discussion took place as to other measures that could be implemented to improve patient flow both in short and long term such as access to nursing care beds, audit of short length stays to provide evidence of poor access to community services and the lack of strategic vision across the health economy. It was acknowledged that 'status quo' was not an option and therefore Executive Directors were asked to consider topics to improve collaborative working with partners and prevent duplication, ideas to be forwarded to Chair via Chief Executive.	**Exec Directors**
BM 18-19/137	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Director of Quality and Governance** – the Board were informed of the positive progress to date across all areas. The revised governance structure is now being embedded across the Trust with the first cycle complete. Mr Moore advised the Board that the CQC inspection notification was imminent and there had been significant progress against the CQC action plan which would be discussed in more detail within item BM 18-19/145. Risk management across the organisation was evolving at pace and the Board should be assured by the improvements. **Director of Nursing & Midwifery** – the Board learned that the response rate to acknowledge complaints was now 100% compliant and the improvement against the target for first written response of 46% compliance. With effect from January 2019 the Divisional Performance Review meetings are to monitor compliance with the agreed end to end process. Since the last Board meeting the Quality buses have visited the Breast Clinic and Outpatients at Clatterbridge and Orthopedics. Some of the topics covered were the importance of patient discharge, Wirral digital and staff survey. **Director of Finance** – Mr David Jago informed the Board that work was ongoing in relation to the strategic pathology collaboration. A review of the Trust activity / clinical coding is underway to ascertain accuracy of coding. **Medical Director** – Dr Stevenson apprised the Board that the Standard Operating Procedure (SOP) for ward rounds was to be revisited to support better patient flow and inform the overall site strategy. A meeting has recently been held with junior doctors to encourage better engagement and discuss any concerns they may have and the subsequent actions to be taken to address them. These meetings will be held on a regular basis to ensure continuity. **Chief Operating Officer** – the Board was apprised that the Urgent Care Clinical senate had taken place earlier in the week. Also at the recent Wirral	

Reference	Minute	Action
	Overview & Scrutiny Committee (OSC) the loss of walk-in centres across the peninsula and the impact for urgent care provided at WUTH were discussed and the Council will be escalating this matter to Parliament. The Board will be informed of any update as and when available. The OSC also highlighted the benefits of the new Musculoskeletal service provided by WUTH. **Mrs Sue Lorimer – Non-Executive Director** – expressed concern regarding the quality performance indicators that were not compliant, this would be discussed in detail under agenda item BM 18-19/141. **Associate Medical Director Women & Children's** – Mr Ellard apprised the Board that discussions are on going in relation to a neonatal services across Merseyside, with the next meeting being held later today. The Division been nominated for a national award at the Royal College of Midwives. Representatives of the Division will attend the event due to take place in March 2019. **Director of Transformation and Partnerships** – Mrs Armes apprised the Board that the first cycle of Strategy development days has taken place with each of the Divisions. Planning guidance for 2019/20 is expected to be issued during December with Trusts likely to be requested to submit both a one year and a longer term plan. A more detailed planning paper will be brought to a future Board of Directors meeting when detailed guidance is received. **Director of Workforce** – Mrs Marks advised the Board that the Trust was looking to establish a partnership with Edge Hill University as the university will be establishing a medical school from 2019 as well exploring how we can work in partnership around nursing opportunities. To date 77% of front line workers have received their flu vaccination and work is ongoing to encourage staff who have not yet been vaccinated. The national staff survey has been circulated to all staff with a response rate of 43%. Divisions have identified champions to urge staff to participate by the deadline, 30th November 2018. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board that activity has increased and improved plans were being implemented to address backlogs. Dr Mehra is currently in the cohort of senior managers undertaking the Trust's 'Top Leaders Programme' and suggested inviting the speaker to a future Board development session, the Board supported this suggestion. **Mr John Sullivan, Non-Executive Director** – to encourage a culture of openness consideration should be given to supporting staff at times of high emotional stress which inadvertently impacts the patient experience. This could be provided through senior leaders participation of the Schwartz rounds. The Board noted that Non Executive Directors, Steve Igoe, Chris Clarkson, Jayne Coulson and John Coackley had no items to report.	**HM**

Reference	Minute	Action
BM 18-19/138	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 1 November 2018 were approved as an accurate record. **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	
BM 18-19/139	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report. **Quality & Risk Profile Meeting –** the meeting took place at the end of October 2018 with NHS England Cheshire & Merseyside and discussed the Trust's draft Quality Risk Profile (QRP). Subsequently the Trust has received a revised copy of the Quality Risk Profile and this will form the basis of the improvement plan along with the CQC action plan and will be monitored as part by the System improvement Board. The inaugural meeting of the System Improvement Board was held on the 8th November 2018 where the tracking of the improvement plan as described above was agreed. **Serious Incidents** - in October 2018 the Trust declared three incidents that crossed the threshold for reporting as a serious incident. Duty of Candour was completed and staff have been supported as an investigation progresses. **Undergraduate Medical Education Quality Visit** – took place on 20th November 2018 and preliminary feedback from the visit was positive with recognition of the improvements since the last visit in 2016. Formal feedback and any required improvement will be agreed & monitored through the Workforce Assurance Committee. **Wirral A&E Delivery Board** - there are a number of system improvement actions being overseen by the Board in support of the winter plan, as detailed in the report. The regulators commended the Wirral winter plan and the additional actions to support resilience. In addition the regulators have requested that Wirral CCG share the financial risk of the additional 48 acute beds required for winter following the health economy demand and capacity work. The executive teams of both organisations are working through the financial impact of this. ***The Board noted the information provided in the November Chief Executive's Report.***	

Reference	Minute	Action
BM 18-19/140	**Patient Story** The Board was joined by Mr Wilson, who apprised the Board of his experience since his diagnosis and is intended to improve the experience of future patients. He did emphasise that his experience whilst an inpatient on ward 21 was very positive. He explained that at various points along his journey lack of information and poor internal communications had contributed his inadequate experience. Had it not been for his vigorous follow-ups when timeframes were not met or telephone calls unreturned. It was suggested that one way to support patients during this time would be the introduction of pre-operation course in conjunction with clinical professional which would allow patients to talk through the process, outlining expectations. Whilst Mr Wilson indicated the areas of concern regarding his experience at WUTH, he also highlighted the poor service of other areas such as the district nurse team. Mr Wilson stated that although his personal experience was difficult he understands that as a consequence of the concerns he has raised improvements have and are continuing within the Urology Department. He thanked Paul McNulty, Deputy Divisional Director – Surgery who had discussed his concerns in detail. On behalf of the Board, the Chair expressed his thanks and appreciation to Mr Wilson for sharing his experience and would welcome further insight and suggestions as to how the Trust can learn from this feedback. ***The Board noted the feedback received from Mr Wilson and acknowledged the lessons learned to improve the experience of future patients.***	
BM 18-19/141	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. The additional exception report provides a summary of the remedial action being undertaken where indicators are not meeting the established targets or thresholds for the standards. Of the 55 indicators with established targets or thresholds 32 are currently off-target or failing to meet performance thresholds. The lead Director for each of these indicators provided a brief synopsis of the issues and the actions being taken. A query was raised regarding percentage of discharges taking place before 12 noon and the impact on performance if there was a 2pm threshold. It was explain that in the two hour window approximately 15 patients could be moved and this could support patient flow from A&E. Other areas of focus for discussion were: • Referral to treatment (RTT) - the Trust is currently achieving trajectory • 52 weeks – slower progress which is being monitored closely with colorectal being an outlier.	

Reference	Minute	Action
	Both of the above indicators are impacted by patient choice eg of 44 patients, 26 exercised their right to delay. The Director of Nursing reported that following the relaunch of hand hygiene competencies Divisions are to audit compliance via the Perfect Ward app. Monitoring of the compliance with be through the Infection Control report to Patient Safety & Quality Board. Following discussion it was agreed that future reports should include clear trajectory targets for all indicators to achieve compliance and an improvement statement based on trajectory. Also identify which the assurance committee is responsible for monitoring which indicator and then the relevant committee to select exception reports to have deep dive topics to clarify the risks and mitigations in place to achieve targets. The Medical Director informed the Board that the VTE redesign process within Cerner which provides an automatic prompt to be trialled for a six week period from December 2018. If this does not achieve improvements then a plan B will be enacted. The Director of Workforce advised the Board that a review of long term sickness is underway which involves an individual plan to be developed for each case by end of November 2018. Plans will then to be monitored a monthly basis through the e divisional performance reviews. A review of the appraisal documentation is currently underway to streamline and focus on discussion, the review will also reflect the feedback provided earlier in the meeting regarding quality of process rather than percentage that have taken place. ***The Board acknowledged that the dashboard identifies the areas for focus where current performance requires improvement. The Board were satisfied for those indicators not yet under prudent control, that action is being taken to improve and future reports to monitor indicators against 'basic, better, best' elements and identify clear trajectories. This being overseen by the Trust Management Board.***	**AM,PM, GW,NS, HM**
BM 18-19/142	**Month 7 Finance Report** The Director of Finance apprised the Board of the summary financial position. At the end of month 7, the Trust reported an actual deficit of £19.4m versus planned deficit of £17.4m, an adverse to plan of £2.0m. The Board was apprised that the underlying deficit is closer to £21m given release of £1.9m of non-recurrent support. The underlying in-month is (£0.1m) worse than plan and delivered a deficit of £1.2m versus a plan of 1.1m. The key driver of the variance is the under-performance of income with elective (£0.6m) worse, non-elective (£0.5m) better and critical care/neonatal £0.1m better. The over-performance on non-elective was unexpected and reflected planned levels of activity and greater complexity in month. The Director of Finance outlined to the Board that the likely forecast outturn deficit at the end of month 7, at circa £28.4m including £1.25m for winter	

Reference	Minute	Action
	pressures. The known risks and opportunities during the remainder of the year which would mitigate/manage the current position to achieve a revised forecast outturn of £28.4m were discussed with further mitigations discussed with the potential to reduce the year end deficit forecast closer to £27.0m. Negotiations continue in relation to a risk share with WH&CCG in respect of both the step down ward and additional 18 beds at APH as part of the winter plan and system wide bed modelling work undertaken. Additional key aspects apprised to the Board included: • Non pay expenditure was above plan at £3.9m, essentially due to MSK outsourcing costs of £2.0m, therefore £1.9m above plan materially driven by outsourcing costs in relation to elective activity at £1.3m. • CIP was £0.6m above plan and had delivered £4.6m versus plan of £4.0m but noted risk re non recurrent savings at £1.9m and a more challenging profile to the latter end of the financial year. • Cash balances at the end of October were £7.0m, exceeding plan by £4.7m driven by robust working capital management and below plan capital expenditure. It was noted that the Board wished to see the drivers of the deficit work progressed in order to inform the development of a financial strategy. An additional Board development session to be arranged for early 2019 to focus on financial sustainability of the Trust and two of the Programme Board work streams – Improving Patient Flow and Operational Transformation. ***The Board noted the M7 finance performance and the proposed year end forecast be considered at the Board development session in early 2019.***	
BM 18-19/142	**Report of Quality & Safety Committee** Mr John Coakley, Non-Executive Director, apprised the Board of the key aspects from the recent Quality & Safety Committee, held on 27th November 2018. The key areas of improvement were: • Control over serious incident handling – improved and now under control. • CAS Alert handling – received assurance that all overdue alerts have been actioned and control achieved over the process. • Falls – rate of falls/1000 bed days is much lower than England mean – falls are reviewed weekly with input from the specialist Matron for Falls and Dementia. • MCA/DOLs compliance shows very strong improvement in Q1 and Q2. • Quality Committee found the new dashboard helpful at making the performance and risk more visible. Improving accountability. • Complaints handling showing signs of improvement. Some of the areas that require improvement are: **Learning from deaths** - a review of concerns raised were discussed particularly in relation to escalation of investigations. The Trust providing external support to offer advice for clinical colleagues.	

Reference	Minute	Action
	CQC Insight Report - Executive leads have been identified to sign off all external reporting to ensure consistency of data. **Water safety management** - action plan now in place and to be monitored by Quality & Safety Committee. ***The Board noted the areas covered in the verbal report.***	
BM 18-19/143	**Report of Programme Management Board** Mr Joe Gibson, External Programme Assurance provided a brief overview of progress to date against each of the workstreams. He notified the Board that the workforce planning workstream would be on line from December 2018. The digital implementation plan for 'go live' to be monitored via the Digital Board and progress reported to Programme Management Board. The Board acknowledged that benefits realisation for each programme are to be clearly defined by the Executive leads and to encompass financial model interfaces with areas such as Divisional CIP's, themes of change programme. Each programme to identify timeframe for delivery eg 12 months, 2-3 years or 4-5 years. This will ensure overall confidence to deliver programme and monitor areas of risk of non delivery. The Board raised concern in relation to the pace of change and emphasised the need for great focus of programme. Communication for staff to be drafted to stress the importance of the change programme and the support available to divisions and corporate areas to achieve the plan. ***The Board noted the Programme Management Board report and progress to date.***	**HM,NS, AM,DJ, PM** **NA**
BM 18-19/144	**Report of Trust Management Board** The Director of Quality & Governance provided a summary report of the Trust Management Board (TMB) meeting on 5th November 2018. The reports outlined matters agreed by the TMB for escalation to the Board: **Outpatient Transformation** - the modernisation programme '*21st Century Outpatients*' will focus on three specific aims: (i) Increasing clinic capacity to return to or exceed planned activity levels before the financial year end; (ii) Review and redesign outpatient structures (iii) Develop and implement transformation which leads to the eradication of paper and drives innovation in delivery of outpatient transactions with service users. **Diversity & Inclusion Strategy** - TMB received and approved the Diversity & Inclusion Strategy 2018-22. **Strategy** – a presentation outlining the proposed strategic objectives and orientating Trust values as discussed at Trust Board was provided and endorsed.	

Reference	Minute	Action
	The next steps will include: (i) communicating and engaging with front line teams to build a strong commitment towards our goals; (ii) focussing more directly on delivery; and (iii) building a culture of continuous improvement supported by transparency, openness, innovation and learning. **Risk Management Committee** – recognised the revised risk management processes reflected recent changes introduced following the CQC's inspection. Its represents encouraging progress, but important to be aware that both the Committee and Policy are new and at an early stage of development/implementation in the organisation. A rolling programme to review all risks is currently underway and the output of those discussions will be presented to future Risk Management Committee meetings. An updated overview of the Trust risk profile will be provided to Board in January 2019. It was noted that Steve Igoe, Audit Committee Chair will be invited to attend the Risk Management Committee. To ensure triangulation of assurances the Trust Management Group received reports from the Patient Safety & Quality Board, Programme Board and the Quality and Performance Dashboard. ***The Board noted the report of the Trust Management Board.***	**PM**
BM 18-19/145	**CQC Action Plan progress Update** The Director of Quality and Governance apprised the Board that the report provided progress pertaining to the CQC Action Plan. The paper provides the Board of Directors with an update on the progress of the CQC Action Plan, and highlights, by exception, any elements of the plan that are not on track or at risk of not meeting target dates for implementation. The actions identified as 'blue' are those that have been completed and embedded. Evidence that underpins completion of these actions is available to Board members to provide reassurance. The actions identified as 'red' are mainly related to operational plans and estates. These have clear timescales identified to progress but some will be a challenge to achieve eg refurbishment – is it affordable and deliverable within the timeframe. ***The Board noted the progress to date of the CQC Action Plan and the corrective actions required to meet the March 2019 deadline.***	
BM 18-19/146	**Appraisal and Revalidation Report 2017-18** The Medical Director apprised the Board of the processes for both revalidation and appraisal for consultants. She highlighted that the Trust is compliant with the Annual Organisational Audit (AOA) standards monitored by NHS England and is now monitored by providing a quarterly statement of compliance. The Trust has appointed a new Medical Appraisal Lead, Dr Catherine Hayle and a new structure for the department introduced with three Senior Appraisers to support the process appointed. Also the Senior Medical Staff Appraisal Policy has been reviewed and updated.	

Reference	Minute	Action
	The Board noted the report and agreed to receive the next report in a year for the period 2018/19.	
BM 18-19/147	**Items for BAF/Risk Register** Board Assurance Framework The Director of Quality and Governance confirmed that the current BAF had been reviewed and updated for presentation to the Audit Committee. Work is ongoing in relation to the development of the BAF for 2019/20. ***The Board noted the future development of the revised Board Assurance Framework.***	
BM 18-19/148	**Any Other Business** There was no other business to report.	
BM 18-19/149	**Date of next Meeting** Wednesday 19th December 2018.	

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Chair

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Date

BOARD OF DIRECTORS

UNAPPROVED MINUTES OF PUBLIC MEETING

19 DECEMBER 2018

**BOARDROOM
EDUCATION CENTRE
ARROWE PARK HOSPITAL**

Present

Sir David Henshaw	Interim Chair
Janelle Holmes	Chief Executive
Jayne Coulson	Non-Executive Director
Dr Nicola Stevenson	Medical Director
Sue Lorimer	Non-Executive Director
Anthony Middleton	Chief Operating Officer
John Sullivan	Non-Executive Director
Gaynor Westray	Director of Nursing and Midwifery
John Coakley	Non-Executive Director
Helen Marks	Director of Workforce
Steve Igoe	Non-Executive Director
Paul Moore	Director of Quality and Governance (Non voting)

In attendance

Natalia Armes	Director of Transformation & Partnerships
Paul Charnley	Director of IT and Information
Dr Ranjeev Mehra	Associate Medical Director, Surgery
Mr Mike Ellard	Associate Medical Director, Women & Childrens
Dr King Sun Leong	Associate Medical Director, Medical & Acute
Karen Edge	Deputy Director of Finance
Andrea Leather	Board Secretary [Minutes]
Mike Baker	Communications & Marketing Officer
John Fry	Public Governor
Steve Evans	Public Governor
Jane Kearley*	Member of the Public
Craig Barker*	Member of the Public / Patient Story
Shelley Gallimore*	Member of the Public / Patient Story
Sue Milling-Kelly*	Patient Experience Team

Apologies

David Jago	Director of Finance
Chris Clarkson	Non-Executive Director
Dr Simon Lea	Associate Medical Director, Diagnostics & Clinical Support

*Denotes attendance for part of the meeting

Reference	Minute	Action
BM 18-19/150	**Apologies for Absence** Noted as above.	
BM 18-19/151	**Declarations of Interest** There were no Declarations of Interest.	
BM 18-19/152	**Chair's Business** The Chair welcomed all those present to the monthly Board of Directors meeting. In opening the meeting, the Chair reminded the Board of Directors that following recent local health economy discussions the establishment of a command centre, led by WUTH to support patient flow at the front door was agreed. This was established for a trial period with the outcomes discussed	

Reference	Minute	Action
	at the Urgent Care Board meeting held the previous day and the forthcoming Chair/Chief Executive meeting later this week. At the Urgent Care Board meeting it was acknowledged that it was hard to establish the effectiveness of the command centre as the system was not running optimally. The UC Board accepted the failure to deliver on key areas agreed previously, namely reduction of stranded patients by 27% across the economy eg 337 patients over 7 days with a target of 228 by end of Q3. The current position is 307 patients after the introduction of additional beds in M3 (Clatterbridge) and therefore the system needs to agree what needs to be implemented to mobilise Q4. The Chief Operating Officers of each organisation were tasked to provide detail of actions to be implement to ensure achievement of the original agreement. The command centre model will continue via dial in with a named individual representing each strategic partner with authority to escalate to Director/CEO. Discussion took place regarding the mitigations put in place to achieve the agreed 27% reduction of stranded patients, were the original assumptions incorrect and what were the consequences to strategic partners for getting it wrong. It was recognised that acuity was higher than expected and therefore had impacted on length of stay, this is now being monitored by Wirral Community Trust. M3 is now fully utilised and is operating well working with the partner. **The Board of Directors supported the escalation of these matters at the Chair/CEO's meeting later this week.**	
BM 18-19/153	**Key Strategic Issues** Board members apprised the Board of key strategic issues and matters worthy of note. **Associate Medical Director Women & Children's** – Mr Ellard apprised the Board that a peer review in antenatal and new born had recently been undertaken with positive feedback received. In addition NHS Resolutions would be reducing the CNST premiums in 2019/20 and that a review of previous claims going back 15 years was under way to establish any trends. The outcomes are to be reported back to the Board. **Mrs Sue Lorimer – Non-Executive Director** – advised that at the recent Finance, Business, Performance & Assurance Committee it was recognised that WUTH CNST premium was higher than other organisations. She reported that the Committee will receive a 'deep dive' presentation encompassing service line reporting (SLR), deficits and divisions contribution to Trust budget, this information will then inform the finance strategy. **Mrs Jayne Coulson, Non-Executive Director** – reported the positive progress to date regarding the outpatients review and highlighted the paper driven processes currently in place that could be networked. **Mrs John Coakley, Non-Executive Director** – raised a query regarding the number of EU staff and the Trust plans post Brexit. NHS providers recently received a letter from Matt Hancock, Secretary of State for Health & Social Care outlining the Governments preparations for a 'no deal' scenario.	

Reference	Minute	Action
	Providers are advised that local stockpiling is unnecessary and could cause shortages in other areas which would put patient care at risk. The Trust is undertaking an internal gap analysis in relation to business continuity should the 'no deal' scenario materialise. **Medical Director** – Dr Stevenson apprised the Board that NHS Improvement and NHS England had issued a directive to remove ambulance waits above one hour to address patient flow issues. To address this additional triage provision will be provided with back up provided by the matrons. In addition North West Ambulance Service (NWAS) have piloted the handover process after 15 minutes between 10am to 4pm. The trial was effective and as some patients were discharged from the corridor NWAS are also analysing data to establish if patients should/should not have been brought to the hospital. They may undertake a further handover trial out of hours to ascertain if there is any impact. **Deputy Director of Finance** – Mrs Edge apprised the Board that a working group had been established to consider the deficit drivers and service line reporting with the outcome to inform the financial strategy. The planning guidance for 2019/20 from NHSI has not yet been issued, it is expected imminently. **Director of Nursing & Midwifery** – the Board were informed that the Trust had recently experienced and outbreak of CDifficile on ward 38 with 6 patients with toxin positive. This exceeds the threshold for November to 19 reported avoidable cases. Work has now been completed to ensure enhanced environmental cleaning and HPV of all areas of the word. There is also increased incidence of Carbapenemase Producing Enterobacteriaceae (CPE) colonisation on wards 24 and 36. This has been difficult to manage due to lack of side room facilities, the 5 additional side rooms are to be opened as part of the 18 additional beds to be provided on the Arrowe Park site. Cleaning standards has been raised as a concern which will be addressed at a meeting with hotel services. Improvement plans to address the current situation have been developed and shared with the CCG, CQC and Public Health England. The Director of Nursing & Midwifery also reported the improved performance regarding complaints as a result of the introduction of the new process and partnership working between PRT and Divisions. **Director of Quality and Governance** – the Board were informed that the draft Quality Strategy had been circulated for consultation to senior leaders. The deadline for feedback is mid January and the final copy will be produced in February. **Mr John Sullivan, Non-Executive Director** – apprised the Board that the recent clinical excellence awards review had shown a breadth of contribution with 62 applications across a range of specialties. To encourage better engagement between consultants and NED's it would be helpful for NED's to have greater clarity of the role of a consultant. Mr Sullivan attended one of the Values & Behaviours workshops which had a good cross section of staff groups. He queried the lack of attendance of	

Reference	Minute	Action
	clinicians at such sessions and it was agreed that this staff group could be addressed through other mechanisms to ensure their participation. **Associate Medical Director, Surgery –** Dr Mehra apprised the Board that the changes on the Clatterbridge site were working effectively. Following a recent ophthalmology review the division had been approached to be an exemplar service. The Board of Directors requested that thanks be passed on to the team. **Director of Workforce** – Mrs Marks advised the Board that the Values & Behaviours workshops have been well attended and received positive feedback. The topic has also been delivered at team meetings and via the quality bus. The national staff survey response rate was 45%. The output would be discussed in detail at the Workforce Assurance Committee and reported to the Board. The team were thanked for all the hard work to encourage staff participation. **Mr Steve Igoe, Non-Executive Director** – apprised the Board that the year end process has been clearly mapped in agreement with external auditors. Discussions regarding the local indicator for the quality report will take place with the Council of Governors. **Director of IT and Information** – Mr Charnley apprised the Board that the Cerner upgrade had now been fully tested and will now go live in January. The Chief Information Officer (CIO) from NHSE is to assess the GDE milestones with sign off expected in January. Discussions with the Countess of Chester regarding the MOU regarding the Cerner contract are reaching conclusion and the final copy of the MOU will be discussed at the meeting of Chief Executive's. **Director of Transformation and Partnerships** – Mrs Armes apprised the Board that Trusts are to submit a 5 year plan in summer 2019 with reference to Healthy Wirral from a system perspective. The Board noted that the Chief Operating Officer, Anthony Middleton had no items to report.	
BM 18-19/154	**Board of Directors** **Minutes** The Minutes of the Board of Directors Meeting held 28 November 2018 were approved as an accurate record with the following minor amendments: **Present** (page 1), Steve Igoe – remove 'Associate' **Item BM 18-19/142** (page 7), para 3 – revise wording to read *'It was noted that the Board wished to see the drivers of the deficit work progressed in order to inform the development of a financial strategy.'* **Action Log** In agreeing the Board Action Log, Board members also gave assurance that actions would be reviewed, addressed and actioned as required.	

Reference	Minute	Action
BM 18-19/155	**Chief Executives' Report** The Chief Executive apprised the Board of the key headlines contained within the written report. **Serious Incidents** - in November 2018 the Trust declared two incidents that crossed the threshold for reporting as a serious incident. In both cases investigations are underway and Duty of Candour properly applied. **New NHS Executive Group: Regional Directors announced** - Bill McCarthy appointed as NHS North West Regional Director. He is expected to formally lead the team from April 2019. His biography to be circulated to Board members. **Cheshire & Merseyside Health & Care Partnership** - sets out how the health and care system can remain fit for the future. The latest edition of the Partnership stakeholder bulletin contains an article on the 'Seacombe birthing suite' as part of the Trusts community midwifery service. A link to the bulletin was provided. **NHSI Provider Bulletin** - **Changes to Seven Day Hospital Services measurement** - the Board assurance framework is the new approach to measuring progress in implementing seven day hospital services (7DS). This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the 7DS clinical standards. A trial period of December – February '19 will enable the Board to discuss and provide assurance. Following this Trust's will be required to implement the Board assurance process in full from March 2019 with supporting evidence from local audits to allow the Board of Directors to give formal assurance of the self-assessment. **Wirral Community NHS Foundation Trust (WCT)** - earlier this year WCT consulted with stakeholders regarding a change of name. In recognition of the feedback received in relation to the importance of the word 'community' which highlights the value of community services and the important role they continue to play with their partners supporting both the health and care needs of the population they serve they have reconsidered the proposed option. They have notified stakeholders that WCT is to be renamed Wirral Community Health and Care NHS Foundation Trust. The change of name will be phased in over the coming months in the most cost effective way. **2018/19 Trust Financial Position** – a conference call based on month 6 submission was held the previous week. The main focus was the planned deficit of £25m and the actions to achieve these namely: locking down activity, CQuins and risks to the cost improvement programme. ***The Board noted the information provided in the December Chief Executive's Report.***	AL
BM 18-19/156	**Patient Story** The Board was joined by Mr Barker and his partner Ms Gallimore, who	

Reference	Minute	Action
	apprised the Board of events following his initial admission in September 2017 with right-sided abdominal pain. He explained that his appendix was removed and he was discharged the following day and did not receive a follow-up appointment. He continued to feel unwell on and off during the next 12 months. In November 2018 he attended the out of hours service as he was again suffering severe pain on the right side and was referred to the Surgical Assessment Unit (SAU). He was admitted and informed that following the appendectomy the appendix had been sent for histology, the results had shown a rare cancerous tumour – neuroendocrine tumour. He was traumatised and very distressed at the news and that he should possibly have received treatment. Subsequently Mr Barker was referred to a specialist at Royal Liverpool Hospital to undergo further investigation relating to his condition. The Medical Director explained that ultimately she is responsible for the care Mr Barker received and apologised for the poor communication during his admissions. A meeting was to be arranged with the Associate Medical Director to address Mr Barker's concerns. Mr Barker thanked the nursing staff who had cared for him during both admissions, they were wonderful. On behalf of the Board, the Chair expressed his thanks and appreciation to Mr Barker and his partner for sharing this experience and the lessons to be learnt to improve communications with patients. ***The Board noted the feedback received from Mr Barker and acknowledged the lessons learned as a consequence of a review by the SUI panel.***	
BM 18-19/157	**Learning from deaths – mortality review and dashboard** National guidance requires Trusts to review 100% of deaths in care to gather learning and improve patient experience. Current performance is at 25% with an agreed trajectory to be fully compliant by Q4 2019/20. A query was raised as to why progress was not gather traction and was the trajectory achievable particularly over the winter period. It was highlighted that previously reviews were only completed by clinicians within medicine and therefore a review of the process was undertaken a decision for all clinicians to contribute. The Medical Director believes the trajectory would be achievable and will appraise the Board if there was any impact over the winter period. A communication has been sent to all consultants and SAS doctors regarding the revised PMR with the expectation for all to contribute. Training has been provided and further sessions will be provided in February 2019. Safety bites bulletins on learning from deaths to be disseminated trust wide on a quarterly basis. ***The Board noted the learning from deaths report and the trajectory to be compliant by Q4 2019/20.***	

Reference	Minute	Action
BM 18-19/158	**Quality & Performance Dashboard and Exception Reports** The report provides a summary of the Trust's performance against agreed key quality and performance indicators. Due to the earlier timing of this month's Board of Directors meeting, the full Issue, Decisions and remedial Action (IDA) exceptions reports were not available. They will be incorporated again for future months. Of the 55 indicators with established targets or thresholds 36 are currently off-target or failing to meet performance thresholds. The lead Director for each of these indicators provided a brief synopsis of the issues and the actions being taken. Areas of focus for discussion were: • Referral to treatment (RTT) - NHSI have stood down the support provided regarding quality of data as the information is now robust and compliant • Cdiff - three cases are currently being reviewed • FFT - kiosks now in place at the front entrance, ED, Women & Children's and Clatterbridge • Same sex accommodation – breach of this target is within critical care. Two additional side rooms are being implemented with an overall improvement plan to be developed. The Board expressed a concern regarding the number of indicators that are not yet compliant within the 'safe' domain. The Director of Quality & Governance reported that progress had been made since the previous month and whilst our focus has been on the rapid reconstruction of essential quality governance systems and processes, it would take longer for the benefits of those changes to be visible in the performance report. In response to a question regarding preparation for CQC inspection, the Director of Quality & Governance agreed that it remains of paramount importance to demonstrate progress in both the 'safety' and 'well-led' domains. It is his belief that there is now greater control and accountability for quality following the changes that have been introduced. He invited the Board to allow more time for those changes to become embedded across the organisation. The Director of Quality & Governance reported good progress across a number of indicators including: • Falls per 1000 bed days – incidence is much lower than the England average • Serious Incidents – threshold maintained since July 2018 • Never events – Zero for four consecutive months • CAS alerts – no overdue alerts for three consecutive months • Harm free care – remains consistent. The Director of Nursing reported that following the relaunch of hand hygiene competencies Divisions are to audit compliance via the Perfect Ward app. Monitoring of the compliance will be through the Infection Control report to Patient Safety & Quality Board. The Medical Director informed the Board that the VTE had reduced slightly and she would expect to see an improvement January onwards following the redesigned process within Cerner which provides an automatic prompt. The Director of Workforce advised the Board that individual plans for long	

Reference	Minute	Action
	term sickness are now in place and will be reviewed on a monthly basis. A new policy for short term sickness will be launched in January '19 and includes the nationally used framework, Bradford Factor. The revised appraisal documentation will be introduced in January and HR business partners will support senior leaders to implement. Of the 10 core elements of mandatory training, only 3 now require face to face training, the others are all delivered via e-learning. A recruitment campaign is due for launch in the new year encompassing social media, Trust website, video and will also reflect the collaborative working with Wirral Borough Council. The pace of change and the impact across the organisation is monitored closely at EMT to ensure the Trust has the appropriate systems in place to monitor compliance and hold people to account. Whilst positive feedback is received from staff, the organisation feels different, appropriate support is in place the level of change can be hard going. is The Board acknowledged that the preparations for the forthcoming CQC inspection must provide a compelling narrative to bring to the fore the many improvements that have been implemented to enhance the quality of care for patients. The thresholds (target) for all indicators are to be reviewed with the relevant Executive lead to meet internal, local and national requirements but enabling flexibility and stretch for the organisation. In addition, there will be the scope to review and consider the range of indicators required to provide effective Board assurance. The revised indicators to be reviewed at Trust Management Board prior to discussion at Trust Board. ***The Board noted the current performance against the indicators to the end of November 2018.***	
BM 18-19/159	**Month 8 Finance Report** The Deputy Director of Finance apprised the Board of the summary financial position. At the end of month 8, the Trust reported an actual deficit of £20.8m versus planned deficit of £18.0m, an adverse to plan position of £2.8m. This is after the application of £2.2m non recurrent balance sheet support pointing to an underlying deficit closer to £23m. The underlying income (£3.2m) worse than plan. The key driver of the variance is the under-performance elective and day case activity than plan predominately from earlier in the year. Improvements are being seen in the levels of activity delivered although it is not expected that the under-performance can be recovered in year. Other income is £0.5m better than plan, mainly the result of specific projects which offsets expenditure. The Deputy Director of Finance outlined to the Board that the likely forecast outturn deficit at the end of month 8, at circa £27.8m. Negotiations continue in relation to a risk share with WH&CCG in respect of both the step down ward and additional 18 beds at APH as part of the winter plan and system wide bed modelling work undertaken.	

Reference	Minute	Action
	Additional key aspects apprised to the Board included: • Expenditure position in month is £0.5m worse than plan and relates to medical pay pressures, some non-recurrent payments in month and supporting staffing gaps through professional fees. • CIP was £0.6m above plan. For the full year the Trust is currently forecasting £8.5m of fully developed schemes with a further £1.9m of plans in progress. • Cash balances at the end of November were £5.8m versus a plan of £1.9m driven by robust working capital management and below plan capital expenditure. • Capital programme has been reviewed by the Chief Operating Officer and Deputy Director of Finance which has confirmed forecast outturn and allocation of contingency with risks reported. It was noted that the Board wished to see the drivers of the deficit work progressed in order to inform the development of a financial strategy. ***The Board noted the M8 finance performance and the risks regarding impact of winter electives.***	
BM 18-19/160	**Trust Flu Immunisation Position** The Director of Workforce apprised the Board of the current take up rate of the flu vaccine in front line employees of 82.3%. The Trust is required to provide a position statement on Flu at the February 2019 meeting and to complete a self assessment checklist which was included within the report. Work is underway to address the areas that require improvement and to look at what actions can be taken to continuously improve our figures through the winter period. The self assessment framework will also be used as a blueprint to plan for next year's flu campaign. The Board thanked the team for the support provided. ***The Board noted the current position in relation to the number of healthcare workers with direct patient contact being vaccinated.***	
BM 18-19/161	**6 monthly Nurse Staffing Report** The Director of Nursing & Midwifery apprised that Board of the planned and actual nursing and care support staffing levels during June - September 2018. The report was considered in detail at the recent Patient, Safety & Quality Board meeting. The ward staffing establishment was reviewed and agreed at the Trust Management Board (TMB) meeting earlier this month, this triangulated approach to staffing decisions of right staff, right skills right place and time. A review will be commenced in January 2019 again using the SCNT tool for general wards and the recognised model Baseline Emergency Staffing Tool (BEST) for the Emergency Department. The Trust will continue to use this methodology until Cerner is able to launch Clairvia (real time acuity and dependency based on clinical entries to each individual patient), an options appraisal will be presented to Wirral Digital Board January 2019.	

Reference	Minute	Action
	The Trust continues to work towards compliance with the requirements of NHS England, the CQC and the NQB Guidance in relation to the Hard Truths response to the Francis Inquiry. With a focus on mandatory training compliance to be at 95% by 31 March 2019 and incorporating AHP into CHPPD data by January 2019. ***The Board noted the six monthly nurse staffing report and the safe staffing declaration.***	
BM 18-19/162	**Report of Finance, Business, Performance & Assurance Committee** Ms Sue Lorimer, Non-Executive Director apprised the Board that at the Finance, Business, Performance & Assurance Committee held on 18th December the Committee had approved a business case for the Carestream Picture Archive and Communication System (PACS), circa £800k within the capital programme 2018/19. The business case had been reviewed in detail at the Trust Management Board meeting. ***The Board noted the report of the Finance, Business, Performance & Assurance Committee.***	
BM 18-19/163	**Report of Trust Management Board** The Director of Quality & Governance provided a summary report of the Trust Management Board (TMB) meeting on 12th December 2018, a copy of the report to circulated. The reports outlines matters agreed by the TMB for escalation to the Board. To ensure triangulation of assurances the Trust Management Group received reports from the Patient Safety & Quality Board, Programme Board and the Quality and Performance Dashboard. ***The Board noted the verbal report of the Trust Management Board and approved the recommendation of a 23% uplift in relation to the ward based nursing establishment.***	**AL**
BM 18-19/164	**Report of Workforce Assurance Committee** Mr John Sullivan, Non-Executive Director apprised the Board of the wide range of improvements and initiatives put in place in 2018 by the Trust's Workforce directorate. Whilst it is appropriate to focus on workforce risks and associated assurance, it was also important to recognise successful workforce interventions and thank the staff responsible. The Committee received a staff story from a junior doctor at the Trust. The story highlighted the potential damage caused by inappropriate staff behaviours and the patient safety risk that can accompany internal conflicts. The Committee agreed it was a powerful reminder of how far the culture needs to change as this was just one department. The Committee were assured that the incident had been followed up and corrective and preventative actions taken. The Workforce Repository and Planning Tool (WRaPT) project will be progressed through the Programme Board with the scope to be agreed at the	

Reference	Minute	Action
	December meeting. A pilot of the tool is planned for the Women & Children Division. The goal is for a Trust wide workforce plan to be in place by end June 2019. The Committee will receive a 'deep dive' on band 5 nurse recruitment, retention and demographics to be presented on a Divisional basis at its next meeting. ***The Board noted the report of the Workforce Assurance Committee.***	
BM 18-19/165	**CQC Action Plan progress Update** The Director of Quality and Governance apprised the Board that the report provided progress pertaining to the CQC Action Plan. He requested the Board consider this report as provisional assurance due to the timing of the meeting ie 7 days earlier than would normally be expected. The Director of Quality & Governance advised that some actions have been 'red-rated' following confirm and challenge meetings on the basis that assurance was not yet available at the time of report. Colleagues are continuing to source and review evidence of progress, and will do so up to and including 31st December 2018. Therefore it is anticipated that there will be an improvement on the overall position against the plan for December which will be confirmed and reported to the Board in January 2019. He reported the very encouraging progress to date particularly with regards to the actions identified as 'blue' which are those that have been completed and embedded. The CQC 'insight tool' is reviewed by the Quality & Safety Committee. To ensure accuracy of data Executive leads have been identified to sign off all submissions. The CQC 'insight tool' uses old data, sometimes from as far back as 2015 and therefore the Board and Committees should bear this in mind when reviewing the report. ***The Board noted the progress to date of the CQC Action Plan and that the month end December data would be presented to the Board in January 2019.***	
BM 18-19/166	**BAF / Risk Register** The Board Secretary advised the Board that templates for each of the Assurance Committees had now been provided in relation to the BAF 2018/19 which enables the Board to received robust assurances. The process for development of the 2019/20 BAF is underway which will be considered at a Board development session. ***The Board noted the report and agreed to receive the next report in a year for the period 2018/19.***	
BM 18-19/167	**Any Other Business** There was no other business to report. In concluding the meeting, Board members reflected on a more strategic	

Reference	Minute	Action
	focus during discussions throughout the meeting which in turn led to constructive challenge and greater transparency. This is particularly pertinent due to the pace of change across the organisation and the Board thanked staff for their contribution during this time.	
BM 18-19/149	**Date of next Meeting** Wednesday 30th January 2019.	

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Chair

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Date