

Minutes of the meeting of the Trust Management Committee held on 25 January 2019 4 March 2019

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Agenda Item No: 12.8

The Royal Wolverhampton NHS Trust

TRUST MANAGEMENT COMMITTEE

Minutes of the meeting of the Trust Management Committee held at 1.30pm on Friday 25 January 2019 in the Board Room, Corporate Services Centre, Building 12, New Cross Hospital, Wolverhampton.

Present:

Mr I Badger	Divisional Medical Director, D1
Ms N Ballard	Head of Nursing – Division D3
Prof. J Cotton	Director of Research and Development
Dr L Dowson	Divisional Medical Director, D2
Mr A Duffell	Director of Workforce
Ms S.Evans	Head of Communications
Mr L Grant	Deputy Chief Operating Officer, D1
Dr S Grumett	Lead Cancer Clinician
Dr C Higgins	Divisional Medical Director, D3
Ms C Hobbs	Head of Nursing, D1
Mr D Loughton (Chair)	Chief Executive
Ms B Morgan	Head of Nursing – Division D2
Mr W Nabih	Head of Estates Developments
Dr B McKaig	Deputy Medical Director
Ms G Nuttall	Chief Operating Officer
Dr J Odum	Medical Director
Ms T Palmer	Head of Midwifery
Mr T Powell	Deputy Chief Operating Officer, D2
Ms S Roberts	Divisional Manager, Estates and Facilities
Mr M Sharon	Director of Planning and Performance
Ms K Shaw	Deputy Chief Operating Officer, D3
Dr M Sidhu	Divisional Medical Director, D3
Prof B Singh	Clinical Director IT
Mr K Stringer	Chief Finance Officer/Deputy Chief Executive
Ms A Tennant	Clinical Director Pharmacy
Dr A K Viswanath	Divisional Medical Director, D2
Dr K Warren	Consultant in Public Health
Ms V Whatley	Deputy Chief Nursing Officer

In Attendance:

Mr Alex (check Mike Sharon)	Deloitte
Ms L Barratt	Paediatric Specialist
Mr J DaCosta	Deloitte (presentation item only)
Dr K Davies	Paediatrician
Mr T Hakim	Head of Capital Delivery
Ms A Lidington	Deloitte (presentation item only)
Ms S Siegel	Deloitte (presentation item only)
Ms H Troalen	Deputy Chief Finance Officer
Mr K Wilshere	Company Secretary
Ms G Zamagias	Medopad (presentation item only)

Apologies:

Prof. A-M Cannaby	Chief Nursing Officer (Part)
Ms C Etches	Deputy Chief Executive (Part)
Dr S Fenner	Divisional Medical Director, D1
Dr J Macve	Director of Infection, Prevention and Control (DIPC)
Mr S Mahmud	Director of Integration
Dr J Parkes	Vertical Integrated GP

Standing Items

18/462: Apologies for absence

Apologies for absence were received from those listed.

18/463: Declarations of Interest

There were no new or changed declarations of interest given at the meeting.

18/464: Minutes of the meeting of the Trust Management Committee held on 23 November 2018

There were no amendments to the minutes.

It was agreed: that the Minutes of the meeting of the Trust Management Committee held on 23 November 2018 be approved.

18/465: Matters arising from the Minutes of the previous meeting

Mr Powell clarified part of a previous Business Case reviewed and approved at the previous meeting. He said the construction costs had now been included in a revised capital case.

18/466: Action Points List

Friday 27 July 2018 18/301: Integrated Care System Update (ICS)

Action: That Prof. Singh and Ms Shaw articulate the risk described with Ms Edwards and provide assurance that the risk either is reflected in a current risk on the Risk Register or that a new Risk is placed on the Risk Register.

21 Sept 2018 BD/KS

Ms Shaw and Prof. Singh said that the situation pertaining to this matter had changed and the action was no longer required. **It was agreed that the Action be closed.**

Main Body of Meeting – Discussion Items

18/467: Topic A - Transition from Children's to Adult Services

Dr Higgins, Dr Davies and Ms Barratt gave a presentation regarding the work on the transition of patients from Paediatric Services to Adult Services. They highlighted the increased need for 'a purposeful, planned process for adolescents with chronic physical & medical conditions as they move from child-centred to adult orientated health care, and a process that addresses their medical needs, - Psychosocial needs and Educational/Vocational needs.' They highlighted the potential benefits and risks associated with transition and improving the process and experience. They referred to the benefits as including improved follow-up, improved patient & parent satisfaction, improved disease control & disease knowledge, improved documentation of adolescent issues, improved health related quality of life and vocational readiness.

They referred to the evidence of what the young people themselves want and the potential impacts on young people of a range of long term conditions and risk taking associated with poor continuity of care. They referred to the proposed Strategy being based on 'developmentally appropriate healthcare' where the developmental phase is taken into account when designing and implementing any transitions. The proposed Strategy was based on the 'Ready, Steady, Go, Hello' process described in the presentation with a process based around the needs of the young person and their developmental and chronological state. This would mean that the concept of the programme being introduced around ages 11-12 years, the Ready phase between 11 and 13 years, Steady 14-16 years and the Go at 16-18 years with the Hello at the 1st attendance in Adult services. They emphasised the need for all services support and involvement in improving the situation including 'champions' in adult service departments to help take this approach forward. They highlighted that a near future Strategy document would be produced and put forward for approval at the Trust Board.

The presentation also included recognition that training would be required and that preparation and adaptation of clinical areas to be developmentally appropriate and the potential use of enabling technology with the young people in terms of managing aspects of their own healthcare.

Dr Odum said he thought the profile of how this could work was important along with the risks if not. He said that a systemised approach would be required. Dr Higgins said it applied to around 1 in 7 young people with chronic and complex healthcare. Dr Davies said it involved relatively small numbers. Dr Higgins said there was an issue where there was no equivalent adult specialist service and where the primary care involvement was paramount. Dr Sidhu agreed that the involvement of primary care was vital to ensure young people with such needs are not lost during the transition. Mr Badger asked about young people from the Children's Hospital. Dr Higgins said discussions had commenced with colleagues about transfer between secondary care providers and primary care. She said that transition between services and across services was important including between specialist and other services.

Prof. Cotton spoke of his clinical experiences and he referred to the consequences of things going wrong and he asked whether data would be collected to provide evidence of the impact of any such programme. Mr Loughton tasked Ms Shaw with confirming a near future action plan. Ms Shaw agreed and highlighted that work had already commenced to provide this including contact across specialist providers, primary care and the potential use of technology in future.

It was agreed: that the presentation and work on improving the Transition from Children's to Adult Services be received and noted.

Action: that the completed Strategy be presented for endorsement to Trust Board for approval.

Action: that an Action Plan for the implementation of the Strategic approach be provided to TMC lead by Ms Shaw in 2-3 months.

18/468: Topic B - Deloitte Assist and ALICE presentation

Mr Loughton introduced Ms Siegel, Mr DaCosta and Ms Lidington from Deloitte. Ms Siegel introduced the initiatives in point solutions in healthcare using new technologies. She referred to the development in partnership with clients around the world across patient pathways. Ms Siegel referred to an A&E simulation tool for planning and analysis, 'Rita' is an automated triage of out-patient referrals using AI currently being developed in Lothian. She referred to the wider benefits of improved GP referrals and analysis of referrals patterns and rates, 'Adam' is a theatre tool and 'Assist' a voice-activated patient bedside tool, 'Flow' a large data AI analysis tool and 'Alice' a simple coding system.

Mr Loughton referred to the potential for a number of these programmes but that the Trust would need to be selective as to those that might want to be pursued given the capacity limits for developing new systems.

Mr DaCosta demonstrated the Amazon Alexa device based system using a demonstration video and a live demonstration of the device. The system understands the request made and logs and prioritises it for staff, it collects and analyses the data over time in relation to patient demands and streamlining the flow of work.

Mr DaCosta showed how the calls from devices were logged and how the communication, flow and prioritisation system worked and he gave the initiative experience from the current demonstration site in Australia.

Mr Loughton asked if the trigger word could be changed – Ms Siegel confirmed that the cue could be changed. He also asked whether it could be part of the smart bed solution being explored with Hillrom. Ms Siegel said they would look at this possibility.

Mr DaCosta also demonstrated the managerial and work allocation aspects of the system alongside the shift management logging and flexibility. He said Deloitte were interested in a first UK based partner to be part of developing the system.

He also gave examples of how the system might be developed in future for ordering tests and as an entertainment system. There followed a discussion of possible options including voice to text and exporting to patient records, use as an intercom, the potential testing for more noisy environments, adaptation to regional accents, adaptability across other languages (13 currently available through Amazon and future links possible), translation potential (e.g. Google translate), linkage across multiple devices. Mr Loughton reminded the meeting that it was a prelude to development. Prof. Singh said that voice record entry was already being explored. Mr Loughton asked how large a clinical area would be required for the initial development. Ms Siegel said around 4-6 areas with a variety of care given. Dr Odum suggested a variety of potential areas. Mr Stringer asked what infrastructure was required. Mr DaCosta said all that was required was a Wi-Fi signal and an internet link for access to the cloud software. Dr McKaig asked whether there had been any associated patient harm incidents reported. Mr DaCosta said none to date.

Mr Loughton asked Ms Whatley and Prof Cannaby to facilitate the link with Hillrom. Mr Loughton confirmed that Mr Sharon and Mr Mahmud were the Trust leads and contacts for this work and for contact with the Teletracking system. Mr Loughton also expressed interest in the out-patient triage system – Dr McKaig said he would be interested alongside e-referral system used.

Ms Lidington then spoke about the initiative to automate simple coding using AI so the coders could concentrate on high level complex coding requirements. She said that initial work had been undertaken applied to cataracts and that the system had proved very accurate and reliable where there were simple and clear rules for coding. She said partners were being sought to develop the relatively simple and straightforward coding tasks. Dr Viswanath said he thought it had potential and asked whether it could do so from scanned records. Ms Lidington said this could be a future development. Mr Badger asked whether it could be done using voice recognition. Dr Higgins said it could be useful in areas where coding isn't currently collected or collated. Ms Lidington said this could also be applied in Primary Care. Prof. Singh said there was a variety of coding recorded but often not reviewed or the data best used.

Dr Sidhu asked about the potential application in Primary Care. Ms Lidington said it could be applied to hospital discharge coding information entry to reduce multiple entry and variation in coding between secondary and primary care. Mr Dowson said it could help in benchmarking against practice in other organisations in relation to mortality. Ms Lidington said there was already a period of double running and learning. Prof Singh and Dr Sidhu said they were interested in the secondary and primary care interface. Dr Odum spoke about areas of potentially greater complexity and the release of coder's time. Ms Lidington said the initial work had been started in straightforward simple procedural areas. Ms Nuttall emphasised the release of complex coding time. Prof. Singh said he was interested in exploring these aspects. Mr Loughton asked Prof. Singh to progress this.

Ms Lidington then spoke about the project (Rita) relating to the use of natural language recognition systems in triaging of out-patient letters. She said this could replace the manual reading and handling of referral letters and the proof of concept undertaken recently with Edinburgh had shown that in Gastroenterology it had been a positive outcome in double running and reducing variation in clinical practice plus the entry of the referral into and along with the patient record. She said that the dashboard also includes wider service variations information. Dr McKaig said he was interested given the data already collected and collated that could be used and applied. Ms Lidington said that outcomes could then be overlaid on the referral information. Mr Badger said that it had been complex to undertake elsewhere. Mr Loughton said that the data set was large. Dr Odum asked whether it included test markers in the body of the letter. Ms Lidington said if the information was in the letter then it could be extracted. Dr Sidhu asked whether it could be taken from an attached report. Mr Sharon asked about the basis for the team. Ms Lidington said the team were UK based with a secure N3 connection available. She said that the machine learning is improved by the data scientists with clinical staff to a high confidence fixed point where the learning and change is then highly controlled.

Prof. Singh highlighted the integrated data set available for service transformation use alongside other partner providers such as West Midlands Ambulance and community services. He said that Public Health had an interest in population information. Mr Loughton signposted the integrated data set shared with GP practices.

Dr Sidhu asked whether it could be stratified by practices and patterns. Ms Siegel said it could. She confirmed the desire to follow up the interest with Mr Sharon and Mr Mahmud co-ordinating for the Trust.

It was agreed: that the Deloitte Assist and ALICE presentation be noted.

It was agreed: that an outline provisional agreement for the Trust to work with Deloitte on the development, evaluation and potential use of the products (Assist, Alice) in principle be approved.

By Exception Papers

18/469: Implementing the 2018 AfC Pay Deal

Mr Duffell introduced the paper and the changed processes – the closure of Band 1 and the introduction of the new pay progression mechanism.

It was agreed: that the Implementing the 2018 AfC Pay Deal approach be received and noted.

18/470: Brexit Planning

Ms Nuttall introduced the paper and the national planning position including recent returns provided on 7 key areas with a Trust Group looking at the local impact. She said that the message remained 'do not stockpile' at this point in time and any contingency was undertaken at a national level. She said more information and communications would follow and the 3 areas of risk related to testing supply chain, again being addressed nationally. She reiterated the unknown nature in most cases.

It was agreed: that the Brexit Planning update be received and noted.

18/471: Financial Year End Forecast of Position

Mr Stringer introduced the report and the current and forecast position, control actions and the cash position with impact on suppliers' payments. He said the figures for the following year would be provided in due course. Mr Loughton asked all staff to focus on 'belt-tightening' in the remainder of the financial year along with activity focus.

It was agreed: that the Financial Year End Forecast of Position update be received and noted.

Items to Note - Monthly Reports

18/472: Integrated Quality and Performance Report

Ms Nuttall and Ms Whatley introduced the report.

It was agreed: that the Integrated Quality and Performance Report be received and noted.

18/473: Division 1 Quality, Governance & Nursing Report

It was agreed: that the Division 1 Quality, Governance & Nursing Report be received and noted.

18/474: Division 2 Quality, Governance & Nursing Report

It was agreed: that the Division 2 Quality, Governance & Nursing Report be received and noted.

18/475: Division 3 Quality, Governance & Nursing Report

It was agreed: that the Division 3 Quality, Governance & Nursing Report be received and noted.

18/476: Executive Workforce Summary Report

Mr Duffell introduced the report and the highlights summarised therein.

It was agreed: that the Executive Workforce Summary Report be received and noted.

18/477: Chief Nursing Officer (CNO) Nursing Report

It was agreed: that the Chief Nursing Officer (CNO) Nursing Report be received and noted.

18/478: CNO Governance Report

It was agreed: that the CNO Governance Report be received and noted.

18/479: Finance Position Report

Mr Stringer introduced the report.

It was agreed: that the Finance Position Report be received and noted.

18/480: Capital Programme Update

Mr Stringer introduced the report.

It was agreed: that the Capital Programme Update Report be received and noted.

18/481: Operational Finance Group Minutes

It was agreed: that the Operational Finance Group Minutes be received and noted.

18/482: Financial Recovery Board – monthly update

Mr Sharon introduced the report.

It was agreed: that the Financial Recovery Board – monthly update Report be received and noted.

18/483: Integrated Care System Report

It was agreed: that the Integrated Care System Report be received and noted.

Items to be Noted or Approved - Statutory or Mandated Reports (1/4, 6 monthly and Annual)

18/484: Property Management

Mr Stringer confirmed that this report had been deferred and that the report would now be reviewed quarterly from April 2019.

It was agreed: that the Property Management Report be received and noted.

18/485: Learning from Deaths (Mortality)

Dr Odum introduced the report. He outlined the report and current position including the current in-patient population. He referred to a national spike in deaths in Q3 including locally and that the SHMI standardisation should reflect this. Dr Odum said the current SHMI would soon be updated alongside the implementation of the Medical Examiner roles which had commenced the continuing work on coding practice and the recent external review that had highlighted a number of areas for clarification and consistency of coding in relation to cause of death and relative risk of death. Dr Odum said that the PwC information would be shared with clinical staff and coding staff in terms of resolving any such queries. He highlighted that incorrect placement with a smaller patient population magnifies the potential impact of any inaccurate coding. He highlighted a national review of the SHMI validity and any required revisions to the future statistical analysis and inclusion criteria.

Dr Odum summarised the work progressed on Sepsis and use of the NEWS2, Palliative Care and End of Life Care changes and additional staff being recruited. He highlighted the work underway to improve the preferred place of death being achieved along with the additional palliative care team support. He also referred to the nursing audits that had continued with interesting emerging information. He said the Mortality Strategy was now available, a revised SJR review process looking at a list of pre-designated conditions along with 10% of all other deaths with second stage review where indicated. He said the report highlighted emerging indicative issues.

Dr Odum said that the Trust had received further CQC alerting group referral letters including Sepsis with the outcome of other previous audit information. He said that there would be further audits to follow. Dr Viswanath said that there was a limited period in which to correct the coding information submitted and processed and this had been prioritised by the clinical staff and coding staff involved.

Mr Loughton asked Dr Odum or Prof. Cannaby to make contact with Sepsis UK to discuss their potential support for the local Sepsis work underway.

Action: Dr Odum or Prof. Cannaby to make contact with Sepsis UK to discuss their potential support for the local Sepsis work

It was agreed: that the Learning from Deaths (Mortality) Report be received and noted.

18/486: Contracting Report

It was agreed: that the Contracting Report be received and noted.

18/487: Tenders

It was agreed: that the Tenders Report be received and noted.

18/488: CQC Insight Report

Ms Whatley introduced the report.

It was agreed: that the CQC Insight Report be received and noted.

18/489: CQC Action Plan Report

It was agreed: that the CQC Action Plan Report be received and noted.

18/490: Midwifery Service Report

Ms Palmer highlighted that in the report there was an item (2.5) regarding challenges in delivering continuity of carers across the whole pathway in the intra-partum element that would add a significant cost pressure to fund the additional capacity. She confirmed it would be taken to the contracting and commissioning group for discussion with commissioners.

It was agreed: that the Midwifery Service Report be received and noted.

18/491: Clinical Fellowship Programme Report

Prof. Singh introduced the report and highlighted the programme being nearly 3 years old. He highlighted the intended benefits and the actual benefits realised in terms of recruitment and attraction of additional medical staff. He summarised the increase in staff and the additional costs incurred. He thanked all the staff involved in the recruitment. He added that there had been benefits related to reduced safety incidents and complaints regarding fellows, and the development of the future consultant workforce. He highlighted the additional costs (11% in total with falling agency spend but increased bank-spend) and that this had not yet been completely reigned in. He therefore referred to future key performance indicators relating to a cap on bank and agency spend in areas with fellows. He said in Medicine spend had exceeded the expected increase for a variety of reasons. He referred to the increased bank spend in continuing hard to recruit to services particularly A&E.

Prof. Singh highlighted the need for future recruitment control measures to ensure the financial position is brought back nearer to the expected position and that future measures would be discussed at TMC. He finally said that the Trust was in the position of making excess staff available to other organisations with further potential accrued benefits. Mr Loughton asked what the measures would be. Prof. Singh said it would be based on agreed required establishment that was being worked upon with a future cap on Bank and Agency staff. Mr Loughton asked whether the other Trusts key staff fully understood the requirements. Prof. Singh said this was being established regarding the future culture required. Mr Loughton highlighted the risks to future recruitment if the quality was not maintained in placements in other organisations. Prof. Singh said he was confident in this.

Dr Dowson said that most bank and agency spend was at middle grade and Consultant level to deliver out-patient activity creating further income, alongside the additional income from the investment in some of the clinical fellows that exceeds the cost of their posts. Dr Odum said that it was a success but with the need for more detailed review of the work and benefits alongside the requirements for further change with more detailed information in 2-3 months' time. Dr Dowson added the increased activity and complexity of the work being undertaken alongside the addressing of trainee workload and the reduction of rota gaps. Dr Viswanath said that it had also built greater resilience into the system when required. Mr Loughton said all agreed it was the right thing to do but that the explanation and management needed to be better explained and controlled. Mr Sharon said that it was agreed as a success but that there needed to be some greater controls in place given that it was contributing to a worsening financial situation. Prof. Singh agreed about the need for greater control whilst not reducing the pace and energy of the recruitment process. He also wondered whether the perceived messages had not been entirely consistent regarding bearing down on bank and agency spends. Ms Nuttall said that if the middle grade position in ED was improved alongside the consultant position in other parts of Division 1 then there would be considerable gains. Mr Loughton drew the discussion to a close.

It was agreed: that the Clinical Fellowship Programme Report be received and noted.

Business Cases - Division 1

18/492: Service expansion for Pre-Operative Medicine Approved by CRG 20/11/18

It was agreed: that the Service expansion for Pre-Operative Medicine Business Case be approved.

18/493: Mortuary/Body Store Expansion Approved by CRG 20/11/18

It was agreed: that the Mortuary/Body Store Expansion Business Case be approved.

18/494: Replacement Telemetry CTG foetal heart rate monitors Approved by CRG 20/11/18

It was agreed: that the Replacement Telemetry CTG foetal heart rate monitors Business Case be approved.

18/495: Replacement of bladder scanner Approved by CRG 20/11/18

It was agreed: that the Replacement of bladder scanner Business Case be approved.

18/496: Replacement of 3 ultrasound machines for Women's and Neonates Group Approved by CRG 20/11/18

It was agreed: that the Replacement of 3 ultrasound machines for Women's and Neonates Group Business Case be approved.

18/497: Expansion of clinic space and improvements in fracture clinic Approved by CRG 20/11/18

It was agreed: that the Expansion of clinic space and improvements in fracture clinic Business Case be approved.

18/498: Recruitment of Consultant Urological Surgeon (new post) Approved by CRG 20/11/18

It was agreed: that the Recruitment of Consultant Urological Surgeon (new post) Business Case be approved.

Business Cases - Division 2

18/499: TAG 528 Niraparib for Maintenance Treatment of Relapsed, Platinum-Sensitive Ovarian, Fallopian Tube and Peritoneal Cancer Approved by C & C 13/11/18

It was agreed: that the TAG 528 Niraparib for Maintenance Treatment of Relapsed, Platinum-Sensitive Ovarian, Fallopian Tube and Peritoneal Cancer Business Case be approved subject to Commissioner Approval.

18/500: TAG 540 Pembrolizumab for Treating Relapsed or Refractory Classical Hodgkin Lymphoma Approved by C & C 13/11/18

It was agreed: that the TAG 540 Pembrolizumab for Treating Relapsed or Refractory Classical Hodgkin Lymphoma Business Case be approved subject to Commissioner Approval.

18/501: Replacement of CT1, CT/Simulator – verbal update Approved by CRG 20/11/18 Approved by C & C 13/11/18

It was agreed: that the Replacement of CT1, CT/Simulator and associated costs including CT, room refurbishment with changing room refurbishment, service contract, quality assurance, bladder scanner and patient equipment used for planning of Radiotherapy patients Business Case be approved.

Business Cases - Division 3 – none this month

Corporate Business Cases

18/502: Finance & Procurement System Business Case

It was agreed: that the Finance & Procurement System Business Case be approved.

Outline/proposals for change – none this month

Policies

18/503: Identification and Management of Female Genital Mutilation Policy

It was agreed: that the Identification and Management of Female Genital Mutilation Policy be approved.

18/504: Medical Handover Policy

It was agreed: that the Medical Handover Policy be approved.

18/505: Dysphagia Policy

It was agreed: that the Dysphagia Policy be approved.

18/506: Any new Risks or changed risks as a result of the meeting

There were no new or changed risks noted from the business of the meeting.

18/507: AOB

There was no other business raised.

18/508: Date and Time of next meeting

The next meeting of the Trust Management Committee will be held on 22 February 2019 at 1.30 p.m. in the Board Room of the Corporate Services Centre, Building 12, New Cross Hospital

The meeting ended at 4.05pm