The Royal Wolverhampton NHS Trust

Minutes of the meeting of the Board of Directors held on 1 July 2019

5 August 2019

The Royal Wolverhampton NHS Trust

Minutes of the meeting of the Board of Directors held on Monday 1 July 2019 at 10 am in Board Room, Corporate Services Centre, Building 12, New Cross Hospital, Wednesfield, Wolverhampton

PRESENT:		
	Prof. Steve Field CBE	Chairman
	Prof. A-M Cannaby (v)	Chief Nursing Officer
	Mr A Duffell	Director of Workforce
	Mr J Hemans	Non-Executive Director
	Ms R Edwards	Non-Executive Director
	Mr D Loughton (v) CBE	Chief Executive Officer
	Ms Nuttall (v)	Chief Operating Officer
	Dr J Odum (v)	Medical Director
	Mr S Mahmud	Director of Integration
	Mr R Dunshea	Non-Executive Director
	Ms M Martin	Non-Executive Director
	Mr K Stringer (v)	Chief Financial Officer/Deputy Chief Executive

(v) denotes voting Executive Directors.

IN ATTENDANCE:		
	Ms S Banga	Senior Administrator, RWT
	Mr S Evans	Deputy Director of Strategic Planning and Performance
	Dr Gopal	Clinical Lead for Organ Donation (item 10.2)
	Ms F Hakkak	Consultant in Palliative Medicine, RWT
	Ms S Evans	Head of Communications, RWT
	Dr Macve	Director Infection Prevention (item 7.7)
	Mr Orakwue	Consultant Obstetrics Gynaecology, RWT (item 7.3)
	Ms Mehay	Freedom to speak up guardian, RWT (item 6.4)
	Ms M Arthur	Governance Manager, RWT (item 9.3)
	Ms K Feist	Senior Sister, RWT (item 6.1)
	Ms X Lopez-Fernandez	Sister, RWT (item 6.1)
	Mr Matinder	Staff Nurse RWT (item 6.1)
	Ms J Sangha	Health Care Worker, RWT (item 6.1)

APOLOGIES:		
	Mr M Sharon	Director of Strategic Planning and Performance
	Ms S Rawlings	Non-Executive Director
	Mr K Wilshere	Company Secretary, RWT

Part 1 – Open to the public

<u>TB.7474: Apologies for absence</u>

Apologies were received from Mr Sharon and Ms Rawlings.

TB.7475: To receive declarations of interest from Directors and Officers

There were no declared changes or conflicts arising from or in addition to the list of declarations provided and reviewed.

Resolved: That the updated declarations of interest by Directors and Officers be noted.

TB.7476: Minutes of the meeting of the Board of Directors held on 4 June 2019

Mr Hemans said that he was present at the meeting. Mr Evans asked that, on page 15, the word 'removed' be amended to read 'reduced'. Both amendments were agreed.

Resolved: Subject to the above amendments that the Minutes of the Board of Directors held on 4 June 2019 be approved as a correct record.

TB.7477: Matters arising from the minutes of the meeting of the Board of Directors held on 4 June 2019

There were no additional matters raised.

TB.7478: Board Action Points

4 February 2019 TB 7198/TB 7148/TB 7378
Maternity Cap and Activity Update Report
Mr Loughton referred to a piece of work underway whose remit was to establish what the maximum physical capacity was for deliveries within the Maternity Unit.

Prof. Field commented that in his view the Maternity suite was a highlight for the Trust and hugely successful. He said that the outcome figures on deliveries and targets within the Trust remained under pressure and that this was in part due to other Trust's referring patients when they themselves were under pressure.

Action: It was agreed that this Action remain open for further updates. It was agreed to re-schedule this for the 5 August Trust Board.

1 April 2019/TB.7327
Capital Programme Update
Mr Stringer provided an update on the Capital Programme and he advised that previous feedback had been taken into account from a number of sources, including the Board. He recognised the pressure that the Capital Programme was under. He summarised the various projects planned and being undertaken. He referred to pressures relating to schemes in specialist pathology and pathology in general. He confirmed that discussions had commenced with colleagues regarding this position.

He said that internal operationally urgent requirements had been reviewed and that he believed the action to be complete. He said that as the operations programme was under pressure throughout the year, the Trust was prioritising matters as they appeared. He said that work was also being undertaking with colleagues in the Black County regarding wider pathology related schemes.

Action: It was agreed that this Action to be closed.

4 June 2019/TB7437
Patient Story
It was noted that this action was in hand.

Action: It was agreed that this Action to be closed.

4 June 2019/TB.7438
Chief Executive's Report
This action was to be noted.

Action: This was agreed that this Action to be closed.

TB.7479: Board Attendance Return

Resolved: That the Board Attendance Return be noted.

TB.7480: Patient Story

Prof. Cannaby introduced the patient story focussed on the Stroke Unit that had been in operation for a year.

The patient in the story spoke about her treatment and her experience of services when she had had a stroke. She said that she was unhappy witnessing a man smoking outside the hospital and said that she thought this was unacceptable. She said that despite this, as a whole she had a positive experience. She praised the West Park staff team for their support especially when she left the hospital and said she was very grateful for all that they had done for her.

Ms Martin said the comment regarding the man smoking outside was very timely as the Trust was proposing to make the entire hospital site smoke free. She welcomed the comment made by the patient as underlining the perspective the Trust was proposing to take and her experience had highlighted the importance of it.

Prof. Cannaby said that the draft revised smoke free policy had been presented at the policy group, that some additional revisions had been required to be made and that these were being progressed.

Ms Martin said that it would take some time to implement the smoke free policy as a whole.

Mr Loughton advised that he had a meeting with a member of the Public Health team to discuss this issue and he had noted that investment in technology would be required to support achieving this. He advised that, following his previous experience as Chief Executive in Coventry, tackling this issue included having options available for monitoring and enforcement. He said that it could not be expected that clinical or support staff enforcing the policy and in the past he had staff subject to related assaults. He said that it needed to be clear that the role of enforcement was part of the remit of the security service.

Prof. Field mentioned that the Chief Executive of Sandwell and West Birmingham Hospitals had been promoting a smoke free trust Twitter campaign over the last few months.

Dr Odum referred to a recent presentation by the Trust's public health team about the emerging approaches to achieving a smoke free hospital. He said there was a programme of work being planned that included culture change, gaining staff engagement and advice and interventions for those supporting patients who did smoke

He concurred with Mr Loughton's comments about challenging individuals and how that was managed was being borne in mind as part of the implementation plan and he believed that the approach proposed was the correct one.

Mr Mahmud said that the work had included looking at how the Trust currently operated and the changes required. He too thought that making smoking unacceptable on the Trust site was the appropriate direction to take. He agreed that enforcement would prove a difficult issue. Mr Loughton agreed with the patient's view and experience and said that he strongly believed the first area to tackle regarding enforcement was people smoking in doorways.

Prof. Field referred to the stroke service mentioned in the patient story. He said that he was hugely impressed by the attitude of staff and was learning how hard they worked, the complexities of the stroke pathway and the amount of work that was undertaken in the emergency department prior to the patient attending the stroke unit.

Prof. Field asked the Board to note specifically the work force issues. He said he had spoken to a number of nurses about how they were getting their extra training so that they could administer medication as well as their own professional training and that he had received some positive feedback regarding this. He said that he was pleased that they had been given the opportunity to develop, grow and be promoted across the different wards. He said he had visited the stroke unit and was impressed by the broader skills mix even despite some of the difficulty in recruiting Doctors within that area.

Dr Odum said the Trust was challenged in terms of recruiting consultants to the service and that this was indicative of a national shortage. He said that the Trust had two locum medical staff and a shortage of consultant staff and that the staff in the Stroke Unit were doing a great job considering some of the pressures they were under.

Prof. Field reported that the only negative issue he had heard of regarded the selection of patients before they arrived at RWT from other Trusts where a number of them had not had a stroke or were not appropriate to refer in to the service. He said one of the advantages of working closer with other Trusts, patients GPs and other Trusts emergency departments was to try and improve the diagnosis and the triage of patients into our services and to then provide the appropriate discharge back to those other Trusts as quickly and efficiently as possible whilst ensuring patient care and safety.

Resolved: that the Patient Story be received and noted.

TB.7481: Staff Voice

Mr Duffell introduced the Staff Voice item. He advised the Board that this was an opportunity to hear directly from the staff 'on the ground' as to what it was like to work for the Trust and what if anything could be done better.

In attendance were Ms Feist Senior Sister, Ms Lopez-Fernandez Sister, Mr Evans Staff Nurse and Ms Sangha a health care worker, all staff from Ward A8 care of the elderly. They raised an issue regarding toilet facilities for the staff. Mr Loughton said he would look at the options available and get back to them in 4 weeks' time.

Action: Mr Loughton to confirm discharge of the options at the next Trust Board.

Mr Dunshea referred to the view that the best possible care for older people was for them to not come in to hospital in the first place. He asked whether the staff felt there were any key messages for the Board what the Trust should be doing with primary care and community services to support this approach.

Ms Feist advised she felt the team was very successful and that the Trust should perhaps consider an expansion in services promoting and support people aging well. She also referred to the Trusts approach of vertical integration with GP's and primary care services and she said it might be an good idea to look at working with care homes and perhaps to consider including them in access to the Trust's educational programmes. She believed if the Trust could better educate care home, residential and nursing home staff that the their practice and care could be improved and thereby potentially reducing admissions to the Trust. She said the introduction of the Community Health Care (CHC) assessors had been a great thing brought in by the Trust. She also said that it might be a good idea to discuss further with providers based in the community settings pre-arranged practical information such as preferential access times and discharge times. Also cut off points, local agreed times with care home as to timings on when patients can go back following their treatment at the Trust.

Prof. Field thanked them for their hard work and their commitment to their patients and their honesty in how the Trust might improve the service conditions.

Resolved: that the Staff Voice be noted.

There was a brief break at this point 11:00 am to 11:05 am

TB.7482: Executive Workforce Report

Mr Duffell highlighted to the Board the action and progress section of the staff survey report. He advised that it was his intention to provide each of the 3 clinical divisions along with estates and facilities, with information and examples of 2 or 3 things that each had done really well, things that they needed to do better and what action each division was taking, making each straightforward, accessible and understandable. He said there would also be a corporate report across the whole trust.

He then referred to the quarter four Friends and Family Test results from the survey conducted at the end of the previous financial year. He said that the Trust had achieved its highest performance of people taking part in the survey. He advised that the results had been positive and that the response rate was better than had previously been seen.

He then referred to the Trust recruitment position and he advised that a dedicated recruitment day had taken place for radiology staff that had been really positive with exceptional recruitment results. He said there had been 107 applications for Band 5 posts and 16 applications for Band 6 posts. He said that the radiology team had held a 'one-off' Saturday dedicated interview day for recruitment with received significant interest given the national shortages and the reported that the recruitment day had gone really well.

He referred to his report stating that the Trust had had more starters than leavers and that his was, on average, running at 30 to 35 additional staff as a net gain every month over the last 12 months and beyond.

He said that, in relation to mandatory training and appraisal, and that given that the Black Country Pathology services rates had been reported separately. He said that he had requested a projected plan and timescale for the service to be back on track. Ms Martin asked what had been asked for assurance from the immediate managers that this would be achieved. She said that she believed that it was at this level where the Trust was challenged by how and when such managers respond to the requirements. She asked what would be looked at to address this.

Mr Duffell said that in addition to the performance management of reporting levels, there were a number of other activities and events including a newly revised leadership delivery programme that would be ready for delivery by August or September 2019. He also referred to a detailed list of management competency skills expected of such managers as part of their roles. He then alluded to the Trust's expanding work programme on service improvement and Clinical Quality Improvement (CQI) work and the continued work being done on staff engagement. He said there were many things which had been done with the immediate managers, a number of which that were listed on the staff survey for staff reference, together with a range of the key actions being taken.

Ms Martin asked whether the Trust would be checking the progress of the different programmes and whether there had been any improvement. Mr Duffell said that one of the things he wanted to achieve was to implement an internal pulse survey to provide greater and more relevant detail about the organisation. He said this would be formed of 10 changeable questions that can be focussed on, for example, areas of concern to provide improved understanding on how to improve in those areas. He said this could be done typically 3 times a year with the national Staff Survey in the 4th quarter. He said as an organisation there was a need to find a way of gathering this kind on information in the quickest and simplest way possible.

Mr Mahmud commented he had had such a conversation about how we do this quicker and the simple way and that he believed this was with the increased use of technology. He said the key thing was for the Trust to get the questions out to staff so as to provide the potential for indications as to whether things were improving. He said that in local services, each different project could have its own set of questions and measures for understanding and improvement.

Ms Nuttall said that the recruitment picture as reported was very positive. She said that despite these successes, the Board should note that the Trust still had areas where vacancy's had not been filled and that this was having a significant adverse impact on service delivery. She said that in particular some beds had been closed on one ward at present because of the inability to recruit and to some extent retain sufficient staff in that area.

Prof. Field asked what the specialities involved were. Prof. Cannaby advised that the areas of concern related to vacancies in a number of areas. She said surgery has a few vacancies' some of these will be vacancies that people had been appointed to so in September the positions will be filled in surgery.

She said the area of greatest concern was staffing in medicine. She reminded the Board not to forget that the Trust has thirty (30) Filipino nurses recruited, most of whom would be headed to the medical wards illustrating that there was a plan and pipeline for staff in some problem areas but also to remind the Board that the Trust was still struggling to recruit in some other areas.

Mr Mahmud said that he was aware that most other trusts had similar issues and that the healthcare staff market was more dynamic and fluid than in the past.

Prof. Cannaby said one of the discussions that she has had with Ms Nuttall related to the issue of staff retention in some 'less popular' service areas. She said the Trust was looking at other options to address this, such as the introduction of practice educators in such areas to help support improving the working environment and the increasing the number of trainees and new nurses gaining experience in that area.

Mr Duffell said that even though the Trust was actively recruiting, the large size might also mean that there could be opportunities to look at enabling a more flexible workforce who could work across other areas or even partner organizations so their skills and knowledge were retained by the wider health system.

Prof. Field said that for him it returned to the discussion with the staff about their environment and needs to best match, meet or exceed these with clear preparation and opportunities for progression in their careers and professions. Mr Loughton advised that in his experience, ward leadership was important as well for the retention of staff.

Resolved: that the Executive Workforce Report be received and noted.

TB.7483: Learning lessons to improve our people

Mr Duffell advised a letter from Baroness Harding had been received following a tragic event in London where a member of staff subject to potential disciplinary process had taken their own life before completion of the process. He said the letter asked what the Trust was doing is relation to 7 key areas. Mr Duffell said that in general the Trust was already tackling a number of these with a few keys areas with room for improvement. He gave a brief overview of those key areas. Prof. Field advised the Board of the importance of this matter.

Mr Dunshea asked whether the next steps had time frames against them. Mr Duffell advised the next steps did have time frames but he had not included them yet. He said he would be discussing the steps with his team and one of the things he would be doing is identifying a set of matrices in September for tracking and reporting progress that would be provided to the Workforce Committee twice a year and to the Board.

Prof. Field asked that as there was no Board in September that this item would be added as a matter arising for the October Board meeting.

Action: Item to be added as an action – matter arising for the October Trust Board meeting.

Resolved: that the Learning lessons to improve our people report be received and noted.

TB.7484: Freedom to Speak Update Summary

Prof. Field welcomed Ms Mehay to speak about the Freedom to Speak Up work. He reminded the Board of the importance of this work.

Ms Mehay introduced the Board report and highlighted a number of items. She said that there had been a couple of cases that had been acted upon in a timely manner. She also referred to cases that had been in the system for some time, either via Human Resources or herself, that had taken some time to resolve and ensure that those involved were kept informed and the process of resolution well facilitated. She said that the numbers reporting through the Freedom to speak up remained low overall and on par with other similar Trusts nationally.

Ms Mehay highlighted Primary care as an area for improvement in terms of awareness and engagement and she said she would like to see more reports from those services. She identified that she was due to meet with a number of practice managers and practices with a view to identifying future champions in primary care. She said at a national level, the National Guardian Office Dr Hughes, had recognised the good practice and development work including that in primary care in Wolverhampton. Dr Hughes had also referred to a Doctor in Leeds who was building up awareness and use of the Freedom to speak up role in primary care also with the support of the national office. Ms Mehay said this would build on a number of open days already held by her in vertically integrated GP practices. She also highlighted to the Board the National Guardian Office preference for in future referring to such issues as people exercising their freedom to speak up rather than 'raising concerns' or 'whistleblowing'.

Prof. Field asked to see the opinions from primary care as a whole regarding the Freedom to speak up initiative as nationally the focus to date had been on acute services. He noted that one of the potential advantages of a vertically integrated Trust was that the Trust could begin to look at primary, community and secondary care aspects. Mr Dunshea asked whether the approach being pursued required further thought and a refresh to the awareness raising campaign. Ms Mehay confirmed that one of the recommendations from a recent internal audit was to update the Freedom to speak up action plan including examples of shared learning where appropriate. Mr Dunshea asked when the refresh plan would be available to the Board. Ms Mehay advised it would be available in December 2019.

Prof. Field congratulated Ms Mehay on her work and thanked her for her contribution. Ms Mahey asked for confirmation of who was the executive lead. Mr Loughton confirmed that it was him as Chief Executive.

Resolved: that the Freedom to Speak update summary be received and noted.

<u>TB.7485: Interim NHS People Plan</u>

Mr Duffell advised that this piece of work was moving forward rapidly. He referred to, on page 5 of the report, that there were originally 6 highlighted areas being addressed nationally which had now been revised to 8. He said it was important to note that any future reiteration of 'our people' organisational development strategy would take these 8 into account. He identified that some of those listed had already been identified and progressed to some degree by the Trust. These would be reviewed in the light of the national information expected in January 2020.

Resolved: that the Interim NHS People Plan be received and noted.

Governance, Risk and Regulatory

<u>TB.7486: Chief Nursing Officer's Nursing Report</u>

Prof. Cannaby introduced the report and the summary points highlighted. Prof. Field asked whether there were any questions regarding the report. Ms Edwards asked what the mortality nursing audit was, referred to on page 4 of the report.

Prof. Cannaby explained that the audit was in respect of patients with sepsis and pneumonia who had died and was focussed on identifying whether there was anything further that could be learned and improved in terms of the care provided.

Resolved: that the Chief Nursing Officer's Nursing Report be noted.

TB.7487: Chief Nursing Officer's Governance Report

Prof. Cannaby introduced the report and the summary points highlighted. Prof. Field asked whether there were any questions regarding the report. He confirmed there were no questions at this time.

Resolved: that the Chief Nursing Officer's Governance Report be noted.

TB.7488 : Medical Staffing Report – Maternity Incentive Scheme

Mr Orakwue provided the Board with an update on assurance of progress with relevant safety actions relating to the implementation of the maternity incentive scheme and that he believed the robust action plan would meet the necessary requirements. He said that from the 1st August the gaps in junior doctors training posts would change and include use of middle grade doctors that would help to provide the necessary training opportunities for all the trainees.

Prof. Field said that in his opinion this was a good story as the organisation had managed to recruit some excellent quality colleagues to further contribute to these additional service improvements.

Prof. Field asked Mr Orakwue how why he thought that the service was so outstanding. Mr Orakwue said in his view, good leadership was a key factor in achieving improvements made to date and in future. He said that in his experience better staffing contributed to improved clinical service quality, higher job satisfaction for staff and helped staff listen better to patients thereby contributing to improved and developed services. He said the organisation was attracting Doctors to and from the clinical fellowship programme. He referred to his recent recruitment drive in Nigeria as positive.

Dr Odum said that he believed the Trust had a great midwifery team, a great head of midwifery together with a very good team of gynaecologists and obstetricians. He said he was pleased to see that senior trainees want to come back to the organisation to get their final experience before they take up a consultant job which spoke for the quality and value they placed on that experience and the service.

Prof. Field thanked Mr Orawkue.

Resolved: that the Medical Staffing Report – Maternity Incentive Scheme be received and noted.

TB.7489: Chair's Report of QGAC

Ms Edwards introduced the Chairs report and summary.

Resolved: that the Chair's report of QGAC be received and noted

TB. 7490: Quality Account (approved at QGAC)

Prof. Cannaby also pointed out that the Quality Account had been to the Board previously and it had been approved by QGAC so this was for ratification by the Board.

Resolved: that the Quality Account be noted.

TB. 7491: Board Assurance Framework

Ms Nuttall asked the Board to confirm the approved new Board Assurance Risk SR13 which related to cancer performance.

Resolved: that Board Assurance Risk SR13 be approved.

Resolved: that the Board Assurance Framework be noted

TB. 7492: Infection Prevention Annual Report 2018-19

Dr Macve introduced the report and highlighted the main summary aspects therein, including 2 methicillin-resistant Staphylococcus aureus (MRSA) attributions and 2 related to care at the Trust with an overall rise in colonisation in hospital along with new *C.Difficile* targets.

She said she was pleased that the Trust was moving towards a reduced risk relating to extremely multi resistant Carbapenemase-Producing Enterobacteriaceae (CPEs). She said the Trust had a programme of screening and isolation of high risk patients and year on year (until last year) the Trust had seen an increase number of patients with but in the last year the Trust had seen a reduction in new patients and had not seen any evidence of spread on the wards to which she said was excellent news.

She said that it had been confirmed that all the new patients identified over the last year were identified through the proactive screening rather than by chance which showed that the screening programme seemed to be working well. She advised however there were some challenges that included 2 externally attributable MRSA bacteraemia in the year and had 2 further cases which were related to outpatient care at the Trust illustrating the need for greater focus on improving screening for MRSA. She advised that over the last year there was an increased colonisation with MSRA.

She said the Trust had a new challenge in terms of *C.Difficile.* She said the definitions had been changed and that the Trust had already commenced using the revisions. She reiterated the importance of maintaining vigilance regarding Infection Control**.**

Mr Dunshea asked how much progress the Trust was making in relation to antibiotic prescribing in what and how much was being prescribed. Dr Macve said in terms of antibiotic prescribing in recent years the Trust had seen a significant decrease in prescribing of broad spectrum antibiotics. She said that however use of broad spectrum antibiotics in the Trust was well above the national average and was now below that average.

She cautioned that a reduced use of broad spectrum antibiotics could mean the start of the use of more than one antibiotic to give the same level of treatment. She said that therefore overall our antibiotic use had increased slightly instead of giving a patient one broad spectrum antibiotic 2 or 3 antibiotics had been used, increasing the overall use.

She said there was an antibiotic stewardship team in the Trust who were looking at this issue. She said that the main key focus at the moment was working out whether there was a way of using the electronic prescribing system efficiently to encourage reduction in use. She said that the Trust was part of a national study using the Antibiotic Kit Review that encouraged clinicians to review the antibiotics being used within 48 hours of starting them and ceasing them if they were found to be unnecessary.

Prof. Field made reference to the flu vaccination rates within the report in the Trust. He said that he had seen the figures from Australia, which were 4 or 5 times higher than this time last year and he said he found it concerning as what happened in Australia tended to follow in the UK 4-5 months later. He said it was important that the Trust maintained had as higher staff flu vaccination rates and coverage as possible.

Mr Loughton advised that, having discussed it with the Director of Workforce that vaccination could become a mandated part of staff's appraisal it would potentially have an impact on their progression unless they had a legitimate medical reason for not being able to have a flu vaccination. Dr Odum advised that not having the vaccine was usually due to an allergy but that this was very rare.

Mr Loughton said this needed to be strengthened as many people within the Trust refused to have a vaccination and it was not due to the reason of not having enough vaccinators it was just that people refused to have a vaccination.

Prof. Field said personally he did not see how someone who cared for patients and worked in a healthcare environment caring for patients would not have a flu vaccination unless they had a valid medical reason not to. Mr Duffell advised that this had in the past been a struggle to get high vaccination rates and he appreciated the Boards involvement and support.

Ms Edwards asked why there had been no non-executive on the infection prevention control group since Dr Anderson had stepped down as a non-executive director. Mr Loughton said that Dr Anderson (a retired paediatrician) was not replaced on this forum as her's had been a personal clinical expertise and interest. He confirmed that the report would be amended to reflect this.

Ms Edwards asked a question about listeria in sandwiches. She asked how the Trust ensured that if sandwiches were brought in how the Trust made sure they didn't go to patients who might be unable to cope with what might be in them.

Ms Nuttall said that she did not think this was something the Trust could manage and that is was to large extent the responsibility of the external companies and their systems and processes. She said that from the recent 'good food event' there was a series of lessons and improvements the Trust could and would take forward. Ms Nuttall said she thought there would be a series of recommendations that would be reviewed and implemented following the report. Prof. Field added that he had spent an afternoon in the Trust catering operation talking to staff and that he had gained an understanding of the Trust systems and was hugely impressed. He said he felt that the Trust should consider offering such services to other NHS organisations rather than outsourcing with private providers.

Resolved: that the Infection Prevention Annual Report 2018-19 be approved

<u>TB. 7493: Clinical Quality Improvement Governance and Oversight Proposals</u>

Mr Evans presented the report and advised that it set out the proposed governance structures to provide assurance that there was effective oversight, governance and management of the Clinical Quality Improvement (CQI) programme.

He said that the programme was fairly new for the organisation having only been commenced in April of this year. He said that there were a number of developments in place including the recent Board Development Session with NHSI. He said that the Trust was endeavouring to ensure that there was effective governance in place at 3 key levels.

Mr Evans outlined that the first level related to the Board and Executive level overview of the programme and its impact alongside a weekly briefing by the Director of Strategy who would provide an update at the executive meetings. He went on to say that there would be quarterly updates in a formal reporting arrangement to a number of groups and committees.

He reiterated that there would be a quarterly update report to the Trust Board and ahead of those reports, the information would be received and reviewed by other groups and committees including the Trust Management Committee and Quality Governance Assurance Committee (both committees of the Board). He highlighted that the Strategy for CQI would sit as part of the Trust Quality Strategy that was being revised.

Mr Evans reported that at an operational level there would be a programme of monthly governance meetings that would provide an opportunity to ensure that any new CQI schemes were clearly aligned with the priorities of the organisation, were properly scrutinised and that approved new plans and work each carried a communication and engagement plan.

Finally Mr Evans referred to the third level of the organisation focussed on achieving wider engagement and ownership of CQI across the Trust. He said as the intention was that CQI would have an impact across all staff roles the notion was to look at how we could potentially improve anything and everything. He advised that there was a stakeholder group in place including representatives from across the whole organisation. He said that this group was in its initial stages of formation and so would take some time to become fully functional. He confirmed that the group was to launch in a fortnight and would be chaired by the Director of Strategy. He said that he believed the overall package represented a comprehensive approach to put the effective governance of the CQI approach and programme in place and he welcomed questions from the Board.

Mr Dunshea asked whether, due to the time and work involved, the Trust knew whether this approach would be beneficial. Mr Evans said that as each scheme required a matrix of oversight and reporting, bringing these together in one structure enabled streamlined reporting to be commenced on a quarterly basis.

Mr Mahmud advised that Mr Evans and Mr Sharon were also very involved in the digital innovation and both were members of the digital innovation forum. He said they believed the revised Quality and Safety Strategy would include moving digital innovation from theory to practice and that the governance process and structure would provide assurance of due process that would eventually be the principles of CQI reflected in practice.

Resolved: that the Clinical Quality Improvement Governance and Oversight Proposals be approved.

Finance and Performance

<u>TB.7494: Report of the Chief Financial Officer – Month 2</u>

Mr Stringer introduced the report for month 2. He advised that the Trust was broadly on plan. He said all these areas were up on contacts and said that although the Trust's pay expenses month 2 appeared to have stabilised and was looking at a slightly lower level but would continue to be closely maintained.

He said that the Cost Improvement Programme was slightly ahead of plan however the target for the first quarter was significantly lower than at the end of the year. He said that the use of resources assessment was taking place on the 1st August with NHSI. He said preparation for this was being undertaken this week and a briefing pack would be made available to the Board. He reminded the Board that work was underway regarding the medium term plan. He said by the Trust would have a category for the medium term place by the end of September.

Resolved: that the Month 2 Finance Report be received and noted.

TB.7495: Chair's Report of the Finance and Performance Committee

Ms Martin said that the Committee was very conscious of the use of the vacancy factor in budgeting and the potential impact on performance.

Ms Edwards asked for a comment to be clarified in the report relating to the breast referral target. She said the figures stated this to be currently 1.1 against 9% she asked whether this was an error in the report. Mr Evans advised the figure should read 93%.

Ms Edwards asked Mr Stringer about the patient income on page 8 of the report as to how much the aligned incentive scheme adjustment was predicted and expected to be achieved and received.

Mr Stringer advised that the organisation was over performing in some areas especially none-elective work. He said he believed over the year this would correct itself. He believed some of the mortality coding work was definitely having an impact. He said that the Trust needed to unpack that mortality work against the aligned incentive contract. He said that it was mainly the none-elective areas that needed focus on because of the aligned incentive contract regarding the elective work.

Resolved: that the Chair's Report of the Finance and Performance Committee be received and noted.

TB.7496: Integrated Quality and Performance Report

Ms Nuttall highlighted the summary on page 13 of the report that referred to the areas of concern for the Trust. She said the most significant issue related to the 2 week wait performance especially for breast cancer patients and those referrals for breast cancer symptomatic patients. She said the referrals continued to be greater than the capacity the Trust had to manage them.

She said that particular, to undertake the one stop shop with regards to the diagnostics, there had been discussion about the vacancies the trust had in, breast radiography to undertake the work. She said there were a series of action plans and meetings being undertaking. She said Mr Loughton, Dr Odum, Prof. Cannaby and herself had been supporting the teams providing reassurance as their senior support and recognising their hard work in rectifying the capacity gaps.

She said she was pleased to report that the Trust would have some additional breast radiology support coming into the organisation and the breast radiographers had adjusted their time tables to further increase patient contacts. She advised that some additional administrative support had been put in place to provide as much as assistance as possible.

She advised that in June discussions with the Sustainability and Transformation Plans (STP) regarding further work had taken place. She said the decision had been taken to assist RWT with other Trusts broadening the Wolverhampton area taking patients that live nearby, GPs would be strongly encouraged/recommended to refer patients to other Trusts with their waiting times are closer to the standard. She said that the whole was a positive development that had not been seen before. She said the communications would be circulated to relevant GPs and other trusts.

She said within the Trust there were extensive discussions and actions being taken regarding the cancer action recovery plan that was regularly reported to the Finance and Performance Committee (F&P) and Quality Governance Committee (QGAC).

Prof. Field mentioned therefore the Trust had a plan on cancer partly focused on recruitment and part efficiency whilst ensuring that quality was maintained. Ms Nuttall said that cancer performance across the country had deteriorated significantly. She said it was positive to see that awareness and demand was increasing but the Trust lacks sufficient capacity to diagnose or treat patients.

Ms Edwards asked why there was a steady decline in cancer performance in the Trust whilst neighbouring Trusts had continued to achieve the 2 week wait. She asked if it was known why RWT had increased demands if the others had not. Ms Nuttall advised demand was rising across the country and the issue was that demand in Wolverhampton had increased at a higher rate than in neighbouring organisations that may also have had additional capacity. Prof. Field said a shortage of equipment seemed also to be an issue.

Mr Hemans said that Ms Nuttall had mentioned that other Trusts used slightly different pathways and asked whether there was any concern for the patients being referred elsewhere would they receive as good patient experience. Mr Hemans asked how different they were. Ms Nuttall advised the pathways were different but met national standards.

Ms Martin asked what percentage of people being referred for 2 week diagnostic actually ended up on the cancer pathway. Mr Loughton replied it was the same percentage as previously. Ms Martin asked whether that meant that all the referrals were appropriate for the cancer pathway. She asked whether some of the challenge was around finding ways to get that initial assessment and diagnostic work done before coming into an acute hospital. She asked whether this was something that could be done out in primary care hubs.

Prof. Field referred to the need for lean pathway across the STP rather than just for patients in Wolverhampton and he welcomed the discussions to date. He said there needed to be redesign across the STP allowing initial access of patients to GPs. He said if this was bypassed going straight to the specialist just moved the initial pressures. He said it was reassuring that the organisation had a plan to move forward.

Ms Martin said that with workforce pressures in Cancer services it was understandable that performance had deteriorated. Prof. Field said he was concerned as demand had increased and that there were increased pressures on and due to a shortage of workforce, scanners and equipment. He also said it was important to maintain the quality of the service delivered despite these pressures. He said that the Trust continued to follow NICE guidance.

Mr Dunshea asked about survival rates and how the Trust had gained assurance of these and whether they also related to Summary Hospital-level Mortality Indicator (SHMI) data.

Prof. Field said that mortality figures were improving and really good work was being done on improving coding quality. Dr Odum advised that the Learning from Deaths programme continued. He said at the earliest that the SHMI figures would look better would be September

and that would depend on whether some projections being done by Price Waterhouse Coopers (PWC) were correct. He said the Trust position would depend on the national position.

He said what the Trust had seen was that the number of deaths in the organisation per se had been lower this year than last year for the last quarter slight reduction in crude mortality. He said the reason for this was as yet unclear. He thought that in September the Trust might see a reduction in the SHMI but he said that was by no means guaranteed. He said unfortunately this month the national adjustment in the calculation for SHMI was being made so all the companies which produced SHMIs were going through the process of doing their own internal changes to their methodology to make sure they were aligned.

He said that PWC was highlighting to the Trust where they thought the relative risk of cohort of patients was underrepresented and each case was then revisited. He said there was some evidence that had had an impact on the Trust's expected death rates.

He said that the work being done with the coders and the clinicians had continued with some evidence that was benefiting the capturing of primary and secondary diagnosis with more to be done. He said this work was supported by PWC in educational sessions for the coders and educational sessions for the clinicians.

He said the Trust had received a response to the CQC submission made 2 months ago regarding alerts and they had questions about the admission avoidance programme. He said there had been an alert regarding Chronic Obstructive Pulmonary Disease (COPD) which was anticipated. He said the Imperial College had written to the Trust to advise on a Quantum Science with Ultracold Molecules (QSUM) assessment as the Trust was now being flagged as an outlier. He confirmed the Trust was doing work regarding to that and advised that there had been quite a dramatic change in standardised mortality rate for COPD which raised other questions that the Trust was investigating.

He said that the clinical pathways for both were linked into the CQI programme, the initial areas being sepsis and pneumonia. He said that although from the narrative in the document the audit was not for pneumonia management it still needed to be rolled out and formalised in the Emergency Department and across the organisation. He said there had been improvement in the compliance with the SEPSIS 6 over the course of the last 12 months and that too was now being formally linked into CQI programme and rolled out across the organisation. Dr Odum said there were a lot of other matters also in the review.

Mr Mahmud also advised that PWC had work regarding data and statistics with a presentation to the Board on the 15th July at the Board Development Session. He said that the statistics were published in June 6 months in arrears and the Trust had more up to date statistics that predicted that the SHMI was likely to go down. He said the work being done was quite reassuring clinically that the data elements the coding team were improving and that the narrative positive regarding clinical interventions, pathways and the CQI programme.
Mr Loughton said that the Board had a further development session planned on cancer referrals and pathways.

Action: Ms Nuttall to provide a further development session on cancer referrals and pathways.

Mr Loughton asked Mr Mahmud to produce a Briefing Pack on the wider work on Mortality and asked him to continue to explore alternatives elsewhere and report back. He said from a leadership point of view the Trust was trying to do everything that it possibly could and there was leadership in place.

Action: Mr Mahmud to produce the Briefing Pack of the work underway and any alternatives.

Resolved: that the Integrated Quality and Performance Report be received and noted.

There was a break 1:00 – 1:30

TB.7497: Annual Report of the Clinical Fellowship Programme – Medical & Nursing

Prof. Field said this was good news with the extension of the programme to Worcester.

Dr Odum gave an overview of the programme that dad been in the making for some 3 years and now available across the majority of the organisation. He said it was now being taken up by other local organisations with the Trust as the host site. He said Worcester, Leicester and North Staffordshire Combined Care Trust and others who had also expressing interest. He said that in due course would be looking seeking further clinical placements. He said the Board needed to be mindful of the enlarging structure and the need to ensure positive oversite.

Prof. Cannaby advised that the nurse's fellowship programme had commenced with 7 nurses from the Trust with 3 nurses from overseas. She said by September/October of this year the number was to increase to 15 with attendees from other Trusts as well as overseas. She said she believed around 50 additional places had been offered to overseas.

Prof. Field supported Dr Odum's view that the Trust had to ensure sufficient capacity, stability and oversight.

Mr Loughton asked whether the Trust should consider asking the Deanery to inspect the organisation. Dr Odum said that was a very good question that he would need to time to consider. He said that a specialist registrar who had now been appointed in the organisation was regarded as a consultant first rate. He said Prof. Singh had written to Dr Hughes to ask if the Fellowship Programme could be formally recognised as an out of programme training structure he had not received a response as yet.

Prof. Field said the programme was very good and he thought the approval of training was General Medical Council (GMC) issue as it comes through having a consultant with a Certificate of Eligibility for Specialist Registration (CESR).

Resolved: that the Annual Report of the Clinical Fellowship Programme – Medical & Nursing be received and noted.

TB: 7498 Revalidation of medical staff

Dr Odum advised the submission of this report required approval by the Trust Board

Ms Edwards asked about the process of revalidation. She asked whether there was any information about how many of those that had been revalidated had also had a signed off job plan.

Dr Odum advised that job planning was not part of the appraisal process. Ms Edwards asked whether it should and could be taken into account. Dr Odum advised not as appraisal addressed the quality of patient management. He said all job plans that included what you are doing, your outcomes performance, CPD and quality improvement initiatives.

Resolved: that the revalidation of medical staff be approved and noted.

Strategy, Business and Transformation

TB.7499: Integrated Director's report

Mr Mahmud introduced the report that highlighted the key points relating to the development of the Primary Care Networks (PCN) and the transformation of the Community Care Services.

Ms Martin wanted to know how Vertical Integration (VI) practices fitted within the CCG having PCNs. She said presumably V.I practices would not be in a PCN. Mr Mahmud said PCNs were developed across the country for people to work together with a level of geographical continuity. He said that the community transformation programme lead by the Trust meant that the Trust would have to engage with all PCN's in Wolverhampton.

Ms Martin asked whether the PCNs would get money from the Trust. Mr Mahmud said yes they would. Mr Duffell asked how many PCNs the CCG had. Mr Mahmud advised there were 6 CCG PCNs. He said that it appeared that the Wolverhampton PCN's were not based on a geographical plan and all the Trust VI practices would be in one PCN.

Prof. Field said he wanted to ensure that there were great outcomes for patients resulting from vertical integration. Mr Mahmud said work need to be done to define such outcomes and the Trust would need to contribute to the public health outcomes, standard social care outcomes, and standard integration outcomes. He said the outcomes included system stabilisation and quantifiable improvements in access for patients. Mr Dunshea queried the ownership of the project and asked who were quality assuring, checking and challenging all this. Mr Loughton said that no one was. Mr Dunshea queried the value of it.

Prof. Field said that one of the reasons he had come to chair this Trust was that he believed that the Trust having community care and GPs presented an opportunity to join-up care for patients in order to improve clinical outcomes and experience. He believed that the Trust had made a positive move towards this. He asked what else the Trust could do to improve the health of the people in Wolverhampton. He said the Trust's integration of public health consultants employed for the prevention of illness was an example of this. He said the Trust had shown leadership but needed to show come outcome measures to prove that is having a positive effect on the heart of the people of Wolverhampton.

Ms Edwards asked about page 5 of the report and for clarification as to what was meant by "It is proposed therefore that the Community Nursing components of the agreed schedules of service which would be expected to be an inherent part of PCN multi-disciplinary and multi-agency working be treated separately to the rest of the Community Transformation Programme and be brought under the governance of the ICA with shared delivery management of delivery between the Trust and the CCG." She asked what this meant for the Trust. Mr Dunshea said he believed this was something that had been previously requested.

Prof. Field said he believed the clinical leadership and vision in medicine and nursing could take primary care to the next level of development. He said he felt that more work was needed and it should be discussed at a further meeting. He said the Board should look at was it was the Trust wanted to do for the people of Wolverhampton. He said there was the potential for the Trust would to do extraordinary things and be proud of it and at the same time try and work out the financial plans.

Resolved: that the Integrated Director's report be received and noted.

TB.7500: Chair's report of the Trust Charity

Resolved: that the Chair's report of the Trust Charity be received and noted.

TB.7501: Risk Management Assurance Strategy

Ms Arthur presented the revised Risk Management Strategy she said that the strategy described the controls, structures, roles and responsibilities that operated to provide assurance to the Board that the Trust was managing its risks. She said some of the key processes in the Strategy related to risk management including the structure and operation from the previous strategy relating to the risk register, escalation process, orders and compliance and sharing lessons of improvement.

She said the key changes from the previous strategy related to risk management training (updated) included the provision of risk management training for all staff and for senior managers. She said the risk management training for senior managers was no longer mandatory however the record would be continued to be kept on the Wolverhampton Medical Institute database and it was important that the practicalities of risk management was still being made available to staff and advised that training would be provided for this.

She said that the Trust Committee Structure had also been updated the Workforce Organisational Development Committee (WODC) had been added together with subgroups.

She said the other key change described the risk management process that the Trust applied to integrated, acquired and expanded services. She confirmed that a risk prioritisation approach to aligning and adapting those systems and processes was included.

She said that over the next 12 months plus the Trust would be placing greater focus on evaluating change and improvement. She said the Trust was developing a change implementation review framework and was working with CQI to help test the impact of actions of the Trust took as part of the CQI to see what improvement if any was being achieved.

Mr Evans commented under the aims and objectives there need to be reference of the updated vision for the Trust for the communities we serve rather than just patients. Ms Arthur noted the comment and said it would be revised.

Dr Odum asked for amendments under the responsibilities to note that he was the lead for Education and Training and not just Medical Education and that Prof. Cannaby was the lead for Nursing Education and Training.

Resolved: that the Risk Management Assurance Strategy be approved.

Patient Safety, Quality and Experience

TB.7502: Learning from Deaths Update Report

Resolved: that the Learning from Deaths update report be received and noted.

TB.7503: Trust Organ Donation Performance

Dr Gopal presented the report. He advised that he was pleased to report that the Trust had received its best organ donation figures over last financial year that it had ever achieve. He said the organisation had 8 patients who went on to become successful organ donors from which 21 patients had benefited.

He said that during the last 3 years organ donation performance had increased year on year achieved by a team effort and by not just complying with NHS BTs and NICE guidelines but by the team ensuring that once a patient was in intensive care on a ventilator and nothing else could be done, that the conversation appropriate with organ donation nursing staff and junior doctors would make the referral to the regional organ donation team who would screen the call and if appropriate send the senior nurse for organ donation to attend. He said this would enable the senior nurse for the donor organisation to be present when the end of life conversation with the family took place.

He said for the last 2 years no patient had fallen through the net with any potential patients coming to end of life where the Trust had had a 100% referral success rate. He said the next steps were to think about implementing systems in the emergency department for patients who were not referred to critical care. Prof. Field congratulated Mr Gopal on the achievements and advised that this was a very difficult and sensitive thing to do. Mr Loughton also congratulated Mr Gopal and his team and advised they had changed the culture and approach positively.

Resolved: that the Trust Organ Donation Performance be received and noted
Chief Executive and TMC Chair Reports

TB.7504: Chief Executive's Report
Mr Loughton advised he had attended the NHS Supply Chain National Customer Board now run by DHL. He also attended the Walsall Health Public Board, the British Royal Red Cross 150 celebration and advised he had started to attend meetings with the Red Cross as they were starting to move into direct delivery of healthcare for the elderly. He said they were introducing different packages of care into people's homes and the work they were providing was mutually beneficial.

Resolved: that the Chief Executive's Report be received and noted.

TB.7505: Chair's report of the TMC held on the 21 June 2019

Resolved: that the Chair's report of the TMC held on the 21 June 2019 be received and noted.

Items to note

TB.7506: Finance and Performance Minutes 22 May 2019 and QGAC May 2019

Resolved: That the Finance and Performance Minutes 22 May 2019 and QGAC May 2019 minuted be received and noted

General Business

Any other Business

TB.7507: There was no further Business raised.
Nothing was raised.

TB.7508: Date and time of next meeting:
5 August 2019 at 10a.m. in the Board Room, Corporate Services Centre, Building 12, New Cross Hospital, Wolverhampton

TB.7509: To consider passing a resolution that representatives of the press and other members of the public be excluded from the remainder of this meeting, having regard to the confidential nature of the business about to be transacted, publicity on which would be prejudicial to the public interest.

Resolved; so to do.

The meeting closed at 2:30 pm