Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION MEETING MINUTES

Venue: Conference Hall, Nishkam Centre, 6 Soho Road, Handsworth, Birmingham B21 9BH

Date: Thursday 4th July 2019, 09:30 – 13:15

Members:		
Mr R Samuda	(RS)	Chairman
Mr H Kang	(HK)	Non-Executive Director
Ms M Perry	(MP)	Non-Executive Director
Mr M Laverty	(ML)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
Dr D Carruthers	(DC)	Medical Director
Mrs P Gardner	(PG)	Chief Nurse
Ms D McLannahan	(DM)	Acting Director of Finance
Miss K Dhami	(KD)	Director of Governance
Mrs R Goodby	(RG)	Director of People & OD
Ms R Barlow	(RB)	Chief Operating Officer
Cllr W Zaffar	(WZ)	Non-Executive Director

In Attendance:		
Mrs C Rickards	(CR)	Trust Convenor
Mrs R Wilkin	(RW)	Director of Communications
Ms C Newton	(CN)	Group Director of Nursing – Paediatrics
Dr N Makwana	(NW)	Group Director - Woman & Child Health
Joined Post-Break		
Ms H Bray	(HB)	Children's Complex Care Coordinator
Ms L Hudson	(LH)	Clinical Nurse Specialist, Paediatric & Diabetes
Ms S Basra-Dhillon	(SB)	Clinical Lead for School Nursing
Ms R Kaur	(RK)	Clinical Lead for Health Visiting
Ms F Mathias	(FM)	Clinical Nurse Specialist, Paediatric Allergy

Apologies:		
Prof. K Thomas	(KT)	Non-Executive Director
Mr M Hoare	(MH)	Non-Executive Director

Minutes	**Reference**
1. Welcome and Introductions	**Verbal**
The Chairman welcomed the members and those in attendance to the meeting. The Trust Board members provided an introduction for the purpose of the recording.	
2. Apologies	**Verbal**
Apologies were noted from Prof K Thomas and Mr M Hoare.	
3. Declarations of Interest	**Verbal**
No declarations of interest were noted.	
4. Patient Story	**Presentation**
Mrs Gardner introduced Simon to the Board and stated that he would present his daughter Aubrey's story. She noted that baby Aubrey had turned 8 weeks old that day. Simon presented the story to the Board with following key points noted: • A couple of weeks ago, 6-week-old Aubrey was not herself. The next day Aubrey was still the same, wouldn't settle and had a temperature. They contacted 111 and asked and were asked numerous questions. Around 10am, 111 called back and booked an emergency appointment at Sandwell for	

11.30am.

- Paediatrics were expected the family's arrival and took them to a bay. It then turned to 'carnage'. It went from one doctor to 9-10 doctors surrounding Aubrey within seconds and Simon and Kristy were pushed to one side, which alarmed them. Simon was requested to go to comfort Aubrey during the chaos. Kirsty had confirmed that a doctor or consultant had tried to update her with what was going on. He was not aware of that as he was trying to comfort his daughter. They were over hearing words such as, sepsis and meningitis, and were being asked questions about the colour of Aubrey's body, if Aubrey always looked and sounded like that. He stated that in that moment it was hard to give a straight answer and an answer that the doctors' required for their clarity.
- Things settled after 5-10 minutes. Aubrey was attached to a monitor, given an antibiotic, she had stopped crying as much and Simon and Kristy were given the time to explain what the doctors' thought was happening. They were taken to Lyndon 1 to their own cubicle. That moment was very frightening.
- The care that Aubrey had received was spot on. She was now home (discharged last Thursday) and was getting back to herself.
- Simon provided the following feedback:
    - Their concerns were not about the care and attention that Aubrey was provided, it was more so when she had a test done (mucus test, faecal sample, lumber punctures, blood test). He and Kirsty were told the results would be ready in 24 hours – when that 24 hours had elapsed; they would get increasingly concerned.
    - When doctors did their rounds in the morning they would ask if they had an update on the results. A lumber puncture test apparently had to go to City as they were able to perform a specific test for the sample – then they were told the next day that they had to contact Heartlands. However, they were told it had gone to City – the hospital staff did not apparently know where the test was. It was the time taken for the results to return – told the turnaround time and were not updated. The Hospital needs to flag the timeframes of results given to patients and when that time approached, to provide an update to alleviate concerns/worries.
    - Could not fault the time, comfort and support they had received from the doctors.

The Chairman thanked Simon for his presentation and welcomed questions from the Board.

Dr Carruthers noted the following aspects for consideration:

- The giving of information during an acute urgent situation.
- The accuracy and the consistency of the message provided.
- The routine update provided to the family.

He queried if the information on discharge provided helpful for the kinds of things to look out for in Aubrey's health and care, the follow up arrangements in place and the outstanding issues that needed to be followed up. Simon noted that they did not have the result on discharge. It was almost put down to a form of viral infection because of the rash that had appeared during their stay and had quickly disappeared within two days. All results returned were clear. The advice on discharge was to be cautious. The white blood cell count was lower on discharge than on arrival, therefore they were booked in for another blood test in one week, and to look out for uncharacteristic behaviours. The day after discharge they were informed the lumber puncture had been retested and confirmed viral meningitis.

Cllr Zaffar noted the importance of communication with parents and carers of patients. People in certain communities and speakers of other languages were known to be reluctant to ask clinicians questions – he queried how sure they were that when they did communicate, how certain they were that it had been

understood. Mrs Gardner noted that it was important to be proactive in reporting updates to parents/carers and that speakers of other languages get an interpreter in a controlled way for understanding (avoiding family and staff).

Ms Goodby queried what facilities were available to Simon and Kirsty when they stayed in the hospital (food, sleeping area, cleaning teeth etc) to ensure they had the energy to care for Aubrey. Simon stated that that they were not concerned with their well-being at the time. They had toilet facilities and were able to brush their teeth. There was a kitchen area and he noted that he thought that there were complimentary snacks. The reclining chair was comfortable enough, but was a bit slippery.

Mr Lewis queried why they were not able to provide the parents with a bed. Mrs Gardner noted that the reclining chair converted into a bed. Mr Lewis noted the informal communication they had and the inconsistency and inability to deliver on certain things. He questioned Simon that upon reflection did he think it would be better to have the informal communication and some aspects of formal communication, as it all sounded a bit ad-hoc. Simon noted that the information would come 90% of the time when the doctors did their rounds and they realised that there was no point in asking questions until the doctor was on their rounds. The informal popping in to ask questions would have been lovely. There was no organised time for discussion between the parents and clinicians.

Mrs Gardner noted that in the adult wards they had quality listening time – they need to consider how to provide that quality listening time in paediatrics to meet with the specialist team at dedicated times.

The Chairman thanked Simon and wished him and his family all the best.

5. Questions from Members of the Public	**Verbal**

The Chairman welcomed any questions from the public.

Dr Sahota congratulated the Trust on their smoke free choice but questioned the pro-vaping promotion. He cautioned promoting vaping to younger people as it would appear that they were safe in choosing the vaping option. The promotion should be limited to those who were trying to quit smoking.

Mr Lewis noted that they were an evidence-based organisation and evidence stated that vaping assisted people to quit cigarettes and it was a better choice than smoking cigarettes – that was why they were promoting vaping to adults. The evidence also shows that it could be a possible gateway for young people to take up smoking. He stated that the retail outlets in the hospitals would be very rigorous about their age verification arrangements.

6. Chair's Opening Comments	**Verbal**

The Chairman noted the following:

- Last time they were here, a family raised concerns over the sickle cell service. Since then they had progressed significantly with the National Blood and Transplant Service to locate more services clustered around their sickle cell specialty. He noted that:
    i. Sickle cell and the transfer of services from London to Birmingham directly arose from conversations in that building four years ago raised by a member of the public.
    ii. Arising from a patient complaint of a young child treated safely, but with poor quality – they would consider a CPAP/BiPAP (assist in breathing) proposal. If it was accepted, over the following six months the service would be implemented at Sandwell which would result in a portion of children that would normally be transferred out of Sandwell would not need to be.
- The result of the GP vote on CCG configuration was 71% remain and provided:
    - Clarity and pathways.

- Enabled them to get support from the STP.
- Start to engage and develop relationships with partners.
- Start to improve pre-emptive care and the connectivity of care between Sandwell and Birmingham.

Cllr Zaffar noted the conspicuous effort of Trust leaders to support GPs and achieve this decision.

UPDATES FROM THE BOARD COMMITTEES

7a Remuneration Committee	**TB (07/19) 001**

a) Mr Kang provided the Board with an update from the Remuneration Committee meeting held in June:
   i. Doctors' pensions – the committee had agreed an interim relief scheme effective 1 August.
   ii. The committee had agreed a long term financing proposal around VSM salaries
   iii. A proposal would come to the private meeting of the Board to introduce performance related pay in 2020 linked to our PDR cycle

7b	**TB (07/19) 002**
People and OD Committee	**TB (07/19) 003**

a) Mr Laverty provided the Board with an update from the People and OD Committee meeting held on 28th June 2019. He noted the following committee discussions:
   i. Revisited rostering, after a disappointing report at the April meeting. The information was now more reliable than at April. There was still room for improvement on performance.
   ii. Vacancies – early good progress. Need to keep up the momentum to deliver the desired targets.
   iii. Went through the SBAF and two of three risks were rated as limited assurance and would keep an eye on those. The Committee had discussed ways to turn them into adequate assurance.

b) The minutes of the People and OD Committee meeting held on 26th April 2019 were received by the Board.

7c	**TB (07/19) 004**
Quality and Safety Committee	**TB (07/19) 005**

a) Mr Kang provided the Board with an update from the Quality and Safety Committee meeting held on 28th June 2019. He noted that:
   - The Committee had reviewed the SBAF and the effectiveness of the controls in place:
     - Limited assurance on home care provision, vulnerable services, and weLearn delivery.
     - Adequate assurance was in place for mortality and R&D.
   - Reviewed the Quality Plan and its trajectory and outcomes.
   - CQC Improvement Plan was reviewed again and going forward there would be a rag-rating process and monitoring of that plan through the Quality and Safety Committee.

   Mr Lewis noted that some indicators in the CQC Inpatient Survey 2018 had remarkably deteriorated (single-sex, a good night's sleep) and that work was being done in those areas. He queried what data would indicate progress made in 3-6 months' time, rather than waiting for the next CQC survey. Mrs Gardner responded:
   - single-sex indicator – a great deal of work had been completed. It was monitored daily at bed meetings and breaches were in critical care when they were deescalated through to the ward-base. The National Policy from the Chief Nursing Officer was still pending, which would

mitigate some of those issues around critical care. Could monitor that to give assurance that they were doing what they could do.

- A good night's sleep – they had taken delivery of two decibel counters. They would measure the measure the noise on the wards at night with the counters (WHO state that anything above 40 decibels was too high). Sleep mats were being purchased for pilot testing – alarmed mat that monitors sleep patterns. The quiet protocol was used to settle patients for the night earlier and stopping the non-patient moves earlier.

b) The minutes from the Quality and Safety Committee meeting held on 24th May 2019 were received by the Board.

7d	**TB (07/19) 006**
Digital Major Projects Authority	**TB (07/19) 007**

a) Ms Perry provided the Board with an update from the Digital Major Projects Authority meeting held 28th June 2019, and noted that:

- There was good evidence of completion rates in Unity preparedness – there were 14 issues of technical readiness and there was good progress in those areas.
- Tap on/tap off – work commenced to enable login and logoff of systems quickly.
- Lower number of outages on key systems.
- Received an update on Unity training rollout – there was a reasonable level of basic training taking place, however there was still a lot of work to do on making sure that people had their service specific training completed, and a series of self-assessments over the coming weeks.

Mr Lewis noted that they had cut the number of P1 outages by two thirds over the last nine months. He expressed gratitude to the IT Department who had worked tirelessly to achieve that result. The remaining P1 outages were predictable and seemed to be the same applications every month (a proportion of those would be remedied by Unity). Over the last 72 of 120 hours, they had experienced a major outage of one of their systems. He had commissioned an independent examination of what happened and expected that would be ready for the DMPA at the end of July. In advance of receipt of that report, it was his view that in an improvement journey that it was expected to experience hiccups.

b) The minutes from the Digital Major Projects Authority meeting held on 24th May 2019 were received by the Board.

7e	**TB (07/19) 008**
Estate Major Projects Authority	**TB (07/19) 009**

a) The Chairman provided the Board with an update from the Estate Major Projects Authority meeting held on 28th June. The following key points were noted:

- The Committee had spent time on the precise contracting form, the level of contingency and the level of incentives in the form (of)/formal contract and an update from the team of discussions with Balfour Beatty.
- Hard FM procurement process, the forward decision points and current position on the competitive dialogue with the sifted number of bidders for the Hard FM on the new estate and existing estate.
- The neonatal reconfiguration changes, which were key to the CQC findings, were on track.
- Concerns around the speed of government processes of which the Final Business Case was going through – they were off track on that. Getting that aligned to run in parallel and not in

sequence – a lot of work with colleagues up the chain to get back on track. The opening of Midland Met Hospital in time for the Commonwealth Games was at risk.

- Capacity of estate management and capability to oversee both the processes they were doing on new builds and the work they had to do for continual improvement. They discussed how that capability would need to change over time.
- Support was provided for the Carter's Green Business Case, and work was progressed on that.

Mr Lewis noted that they would get there but there were some challenges, they were in want of two approvals:

i. Taper relief letter – non-recurrent revenue. Had the approval and the letter, but not the signed letter.

ii. Commercial close approval – Balfour Beatty were meeting with NHSI today. To succeed they needed to help civil servants work within the commitment given by ministers – which was concurrent approval and not sequential approval between the regulator and two Whitehall departments. They were working to achieve that.

Mr Lewis requested that Ms McLannahan provide the Board with a reminder of what the life cycle was in regard to the Hard FM procurement. Ms McLannahan stated that it was the regular maintenance and upkeep of their estate on a prospective plan basis rather than a reactive point of view. It covered repairs, backlog maintenance and statutory standards compliance. The Hard FM procurement had two sections; Midland Met Hospital life cycle maintenance and the retained estate. She noted that she was working through the Hard FM procurement proposal to ensure that they had financially accounted for that – that the capital and revenue accounting treatment was appropriate.

Mr Lewis suggested that the Trust is buying out £140m of backlog maintenance and replacing a Victorian City Hospital. They would fail in their obligations if they did not construct a set of obligations that would likely recreate that backlog maintenance in the next three decades.

b) The minutes from the Estate Major Projects Authority meeting held on 26th April 2019 were received by the Board.

MATTERS FOR APPROVAL OR DISCUSSION

8. Chief Executive's Summary on Organisation Wide Issues	**TB (07/19) 010**

Mr Lewis provided the Board with the following key points from his paper:

- Smoke free from 7am, 5 July 2019 – he referenced the vaping approach outlined earlier.
- Unity – they need to be clear on the countdown to Unity:
    - Various technical implementations to start in August.
    - A technical cutover in mid-September ready for an operational cutover for the morning of Saturday, 21 September.
    - Need to be clear with DMPA, at the end of July, that the Trust level input criteria were agreed and approved.
    - Need to meet the 11 individual competencies, dual signed for as specified number of employees. Team readiness and team simulation to pass those tests. Once Team simulation was passed, they would be externally auditing.
    - Cut planned care activity by 40% for the two weeks after 23 September. Need to pull out of that downswing two weeks after or they would be at risk of income risk. They were not allowing people to book leave for a period of time. BMA had informed that was not legal,

however their opinion was wrong, but noted. They would rescind that bar next week when they would be clear of staffing levels that were required.

- Section 3.8 in the Paper described a 92% of imaging compliance at June, and in the annex it was 87%. He noted that 87% still placed them above other NHS Trusts.

Ms Barlow noted the following in regard to Imaging:

- Go live with the reporting partnership over the next two weeks with one of their partners.
- Centralised the booking component of non-inpatient work to the booking team – big improvements there.
- Cutting their two-week waits on outpatient and urgents were at 100% against their targets.
- Expected that they would report next time to the Board that they were well into the 90's with 100% performance in two-week waits all outpatient performance. Had a little bit work to do with in terms of improving inpatients.
- Workshop with A&E as to when the clock starts.

Mr Kang noted section 5.3 of the Paper, Partners and Commissioners. He questioned if they were communicating with the communities whose first language was not English around bowel screening (as they were under represented). Mr Lewis noted that:

- locally, regionally and nationally it was an acknowledged issue.
- They had an extended access team who were working to design ways to make the program something that people wish to take up – for both breast and bowel screening.
- They were moving towards an influencers model.
- It was clear that all their literature, videos and material were in English – which would be remedied in the next weeks. More broadly, the Trust has 29,000 interpreting contacts each year from over 2 million patient contacts. They would set out a plan in December.

Mr Laverty noted that the inpatient survey was disappointing, and questioned how that fed into the next CQC and its importance. Mr Lewis advised that they were trying to mitigate that through monthly meetings with the CQC – the risk was the CQC taking their data instead of the local data. He was pushing for their purple data/friendly data to be viewed with equal prominence by the CQC.

Cllr Zaffar noted section 5.2 of the paper and commended the work on air quality – the presentation at the AGM was brilliant. He stated that the work they were doing internally and externally should be congratulated.

Mrs Goodby questioned when they would go into the Public Health Plan elements of obesity to make the most of the national campaign. Mr Lewis noted that during the month they were consulting staff on the best response to obesity for young people, adults and staff. They had tentatively agreed with the Council to co-design a strategy between now and the end of September. The Director of Public Health for Sandwell was to attend Dr Thomas' committee at the end of September with that topic in mind. There was some work to do in content as there was a discrepancy in the approach to obesity (in regard to mental health).

Mr Kang queried how far off they were from PDR completion. Mrs Goodby advised that the completed, recorded and verified by the line manager on ESR was 58% - however, completed and *to be* verified would take that number to 89%. People with nothing completed was 6%, however they had added the verification of the line manager this year. The extra verification for moderation was taking that little bit of extra time. Mr Lewis noted that staff on the wrong side of the line may find themselves scored a 1 or zero. They would need to distinguish between the line managers and employee's fall downs. He noted that they wanted all staff moderation at the beginning of August.

Miss Dhami queried if Organ Donation could be readdressed by the Board. Mr Lewis provided an update:

- There was a Trust Organ Donation and Transplant Committee – it had been agreed that the Committee would propose to the Board some specific forward targets – a proactive approach model.
- They would hold off on any transport advertising until they were clear as to what fleet they would be running (potential electric fleet).
- Tissue donation would need to be addressed as it was a specific BMEC question.
- The proposal was due at the October Board with expectations on tissue and organ donations for the year.

The Chairman flagged residents with learning disabilities and questioned if they had a target date. Mr Lewis noted that thought it would be tracked for the September Board.

Ms Perry questioned if they could have some new arrangements in place for mental health patients. Mr Lewis noted that they had fallen down in the CQC Report on tracking who were formally on section. They had commissioned the Birmingham and Solihull Mental Health Trust to provide that administrative function for them – that would be in place by the beginning of August.

9. Integrated Quality and Performance Report – May	**TB (07/19) 011**

Dave Baker noted the following:

- He orientated the Board with some changes to the IQPR. There were two new pages; the *Exception Report for the Persistent Reds* and *Other Exceptions*. As a result of feedback to simplify the Report that they had included graphs and trajectories.
- Open referral initial work had been completed and on time. It left 15000 patients to do further review on by clinical group and was flagged for completion on 17 July 2019.
- The Stroke Ward admissions missed its recover date on the persistent reds. Since then there was a Stroke Symposium.

Mr Lewis noted that his sense would be the end of July to close off the open referrals – and not any longer than July. He noted that they had tried multiple times to resolve the overall issue and it would need to be taken to a committee or to the Board in August to find a fix.

The Chairman queried the MRSA screening levels that were below target. Mrs Gardner noted that at the Trust they screened everyone, however; the National Standards did not require everyone to be screened. Therefore, they had switched to the National Standard. She had asked Infection Control to reiterate who required screening and hoped that number would improve.

10. Risk Register Report	**TB (07/19) 012**

Miss Dhami noted that the CLE reviewed the risks that they had across the clinical groups and corporate directorates. All amber and red rated risks were reviewed for their robustness of what they were testing with the risk assessment. They were able to filter out those risks that were actually an issue. A number of risks were found that were to be archived and a number where the likelihood or the impact were not quite right. It was a useful exercise and the leadership had developed as a result; they were able to compare their risk assessment level to other areas (re-evaluate the importance of their risks).

Mr Lewis noted that this could be taken to suggest a wholesale failure of the wider risk management arrangements. They had a remedy for implementation by the end of the year. They would need to specify now, a Q4 audit of their revised arrangements so they could assess their progress at the end of the year.

Mr Laverty queried if peoples risk management responsibilities were reflected in their PDRs. Miss Dhami confirmed they were not in that way but adherence to our processes are a core competency in key job descriptions.

Ms Perry noted that it was important for those risk conversations to be filtered down from senior leaders to other areas of management so that risk culture becomes embedded in all levels across the organisation.

Mr Kang queried who actually owned the risks – no matter what resources were corralled for it; it was that person's responsibility. Therefore, it should be in the PDR. Miss Dhami noted that there was a risk owner who updated the risk and ensured that it was progressing.

The Chairman queried the connectivity to anything that the CQC focus on in terms of risk competence. Miss Dhami noted that the CQC want to see people being able to talk across all levels of the organisation about risk.

BREAK

The Chairman welcomed the Children's Services attendees that had joined the meeting post-break. He noted that one in six of their patients were young people and that was why they had dedicated a large portion of the Board meeting to young people's care. It was particularly true that the NHS were going to get more pre-emptive about managing Public Health, and young people and children were the key to that. It was also a very important touch point to other partners in which they interacted with in the Public Health Agenda.

11. Quality Plan: Thresholds and Trajectories	**TB (07/19) 013**

Dr Carruthers noted that the Paper was a follow up from a discussion at the June Board around the Quality Plan, and to build on the discussions had with the Group Directors, relevant clinicians or ops staff involved in the nine areas of the Quality Plan. At the discussions they:

- Reflected on the work that had already been done (in progress status) – split into three main sections.
- Responsibility and oversight of responsible areas.
- Timeline and outcomes for projects.

Mr Lewis queried if it possible to get their current performance and target performance levels in a data form that the Board could view. Dr Carruthers noted he was in discussions with informatics to confirm the data. Mr Lewis noted that they were looking at a small credit card sized card that everybody in the Trust could have that identified the ten indicator targets. Dr Carruthers noted that one of the challenges in pulling together an overall figure for the area were the multiple areas, specialties that they covered and how the work needed for each of those areas would be very different. Mr Lewis confirmed that they would need the aggregate number to identify their target.

Mrs Goodby noted the end of life care and the patients' choice of where to die. She questioned if the local government was involved in that due to the authority that they had over care homes, and would they consider a joint campaign. She also queried if the rituals of various religions at the end of life care were considered in the planning process. Dr Carruthers noted that 80% of patients died in their place of choice. The cultural sensitivity considerations were something that he would raise with the team.

Mr Laverty noted that at Extra Care they did a lot of end of life care. In their experience, the barriers were that the GPs were reticent to support end of life at one of their villages – they were more likely to refer them on to hospital. A lot of work had been done with GPs to put plans in place to support people at the end of life. Dr Carruthers noted that it showed how the link between what happens in the community and in the hospital. The end of life team with their Palliative Care Hub were good at informing patients and their carers of the support available at the Hub. It's about making that resource available to more people.

Mr Kang questioned why some of the comparative data was at a national level and some local, was there a void at a national level. Dr Carruthers noted that the projects were as they were designed in 2016 and it had been agreed to focus some aims on regional excellence and the rest on national pre-eminence. The

thresholds would return to the August Quality and Safety Committee and the September Board.

12. Sickness Turnaround Trajectory and Plan	**TB (07/19) 014**

Mrs Goodby introduced the requested turnaround plan.

- Sickness absence levels were at 4.7% in May, which was a slightly decreased position.
- The Report set out the plan to:
    - Reduce mental health absence
        - Fully implement the mandated mental health risk assessment – agreed by the Board but not operational as yet.
        - Appoint an Attendance Coach to assist with staff that were off sick with mental health illness and in particular people that were undergoing any investigation procedure, in particular medical staff.
    - Revise the approach to musculoskeletal issue (MSK) absence.
        - Started good work with Therapies in conjunction with the Occupational Health team – had a new clinician leading that partnership.
    - Refocus on ward absence
        - In the Financial Plan and Agency Reduction Plan they would need to get ward areas down to 3% sickness. Focusing on the hotspot areas with a new approach.

Mrs Gardner queried if there was any evidence to indicate that staff were returning to work before they were fully well, and how they could encourage staff to stay way until they were fully well. Mrs Goodby noted that people often need to go back to work for their own mental health and recovery, and they were paying them anyway. They could involve them in work in a phased rehab back into the workplace to reduce the overall length away from work. Some ringfenced roles for this purpose would be introduced.

Mr Laverty noted the correlation between sickness absence and investigation. He suggested that may be worth looking at the time taken to complete investigations – they may be treating a symptom rather than the cause. Mrs Goodby noted that it was a fully resourced plan and the groups would be fully involved in it. The investigation side had been a perennial problem. They had closed down a lot of investigations in the last two months and recommitted to the prior 8-week turnaround in their case work investigation unit. Mr Lewis noted it would be helpful to have a one-page document that detailed the circumstances in which they would cease payment to someone who was off sick if they were non-compliant. Mrs Rickards noted that the investigations tended to be very long and that it was an issue to send someone back to a work area where there was a potential problem/conflict. The Chairman asked for assurance that these two issues were being addressed.

13. Overview of Children's Services	**TB (07/19) 015**

Dr Nick Makwana thanked the Board for providing the opportunity to discuss the Children's Services available at Sandwell and West Birmingham. He noted that:

i. Children are not small adults
ii. Children develop and grow – you're not looking after the finished product, rather how to improve health and aspirations.
iii. Not looking at them in isolation – they are part of a family. They need to focus on the whole family to get the desired outcomes for the child.

They were very fortunate to be a team without walls and they had a real opportunity to make a difference to children and young people.

He noted the following key points:

- Strengths:
    - Improve assessments for children with autism.
    - Work with local authorities with population health.
- Weaknesses and Opportunities
    - Their weaknesses were also opportunities for staff and service improvement and provide better health care to children and their families.
- Threats
    - Unsure if they would transpire, a few ideas of ones that would include:
        - Pathway changes.
        - Changes to services.
        - How nursing and medical staff work to deliver care.

They want to ensure that children and young people were involved at all levels – which was something that the CQC pulled out and were working to change that.

The Chairman called for specific questions on the strategic elements from the Board.

Mrs Gardner noted that it was difficult to get feedback from young people and families and queried if there was a plan for a more robust system to gather feedback. It was noted that they would conduct patient focus groups and reach out to the community team for ideas on how to involve young people in the development of their service. It was a work in progress.

Mr Kang noted teenage mental health issues and queried their relationship with the third-party support organisations. Dr Makwana noted that they worked very closely with the Children's Mental Health Services across site. They were one of the few trusts that had a Psychologist based within their service who support children and young people with chronic conditions.

Mr Lewis queried if they wrapped the services around the families in a holistic manner in which they would hope. Dr Makwana noted that they did not and that what they want and what they had was very different. They would discuss those aspirations and define a very clear timeframe.

Mr Laverty noted that there was a lot of work going on and queried how they decide on their priorities. Dr Makwana noted that the immediate priorities were:

i. Pathway redesigns based on the CQC Report.
ii. Cooperative working with local authorities and their services.
iii. Utilising teams within the community to look at things like obesity and mental health.
iv. Working with GP partners on childhood asthma.

Mr Lewis noted that over the next three months they would develop a Strategic Statement for Children for the organisation and would bring that back to the October Board.

Miss Dhami queried to what extent families and parents were influenced by the CQC rating and when would they achieve an *outstanding* rating. Dr Makwana noted that most people were influenced by word of mouth – which was very positive about the Trust. They were not losing business and were increasing business as the service was preferred. They would achieve an *outstanding* rating within the next 24 months. This ambition was welcomed by the Board.

Ms Perry noted that success was partly dependant on the happiness of staff. She queried if the loss of staff to the Children's Hospital would form part of the strategy. It was noted that they were looking at staff development and had plans in place to hold staff discussions about development opportunities, what makes the Trust a great place to work to want to continue their career with the Trust, and workforce planning across the group. Dr Makwana noted that some of their services attract staff in and there were

plans in the pipeline that would result in less attrition due to development opportunities.

The Chairman noted the reference to an *autocratic style of leadership* in the Paper and welcomed expansion on that. Dr Makwana noted that that work had commenced with new leaders in place. The new ideas, drive and enthusiasm had already been well received among staff.

13.1 Health Visiting Services	**TB (07/19) 016**

Randeep Kaur, Clinical Lead for Health Visiting, noted the following:

- The Paper focused on their universal offer, talk about the public health issues, how they actively fit into the better integrated care organisation, and the 2020 Public Health Plan.
- Health Visiting Services was a team of highly skilled individuals, nurses and/or midwives that had taken on a specialist course to be public health nurses.
- Focused on 0-5 years of age.
- The child was kept at the centre of care, but did wrap around the family as family issues impact on children significantly. They had a Health Care Needs Analysis that looked at issues around parenting capacity, environmental issues, meeting their education needs.
- Sandwell managed to attract health visitors and did not have an issue recruiting staff.
- Other organisations came to them to see best practice.

Mr Lewis agreed that they ran a fantastic service and preferentially people wanted to work for their service. He agreed that there were a lot of things that they could do. He wanted to focus on readiness for school. He questioned what current proportion of local children in Sandwell were ready for school and looking forward 2-3 years, how much better could they make it. Randeep Kaur noted that they had a red-light system that sent letters out to parents that asks parents if their child had specific needs to make contact around the school age. They would like to work towards a pre-school program – potty training, dietary advice. Nursery aged children was where the focus on school readiness should be placed.

Ms Perry noted that they clearly had good partnerships with other agencies and questioned if there were any other hotspot areas where they were particularly having trouble engaging partnerships. Randeep Kaur noted that there was a high transient population and vulnerable families in Smethwick. They were not there long enough to engage with. They had support from a specialist team and good working relationship with the housing associations and refuges to support that.

Dr Makwana to advise on school readiness measure at September Board	

13.2 School Health Nursing	**TB (07/19) 017**

Shawinder Basra-Dhillon advised the Board that Sandwell school nurses had never moved away from Sandwell and had always delivered services in Sandwell. They wanted to improve their integration with the acute and make sure that the partnership was robust. She noted that:

- They worked in the same way as the health nurses, but their spectrum was 5-19 years of age.
- Did not work in isolation – work with families using caution as the child had a voice and was often very clear about what they want – ensuring that they were advocates for young people.
- Focus groups – school nurses run the Ambassador project. Young people selected by their school to run a health program around emotion, health or wellbeing.
- Can't speak write it down – sexually exploited children where it was unsure if they were being monitored when speaking to nurses. Encouraged to write it down instead. Would like to implement that as a pilot in to the Acute.

Mr Lewis requested 2-3 things that should be included in the Obesity Strategy. Shawinder Basra-Dhillon noted:

- Work with community groups around cooking/nutrition education.
- Work with public health community workers who signpost those that need help.
- The work done in school.

Mr Lewis questioned if there was there a place in the country that had made significant progress in tackling Year 6 obesity. Shawinder Basra-Dhillon noted that the Wake and Shake Program should be embedded into all of the schools as physical exercise was also important and ensuring that families were also involved.

Mr Kang questioned if they were providing support for those that were seeing the exploitation of children. Shawinder Basra-Dhillon noted that when they do their holistic case assessment, it was the way in which they asked the question – using the right tools and the young person needs to be listened to and provided with the support. On the staff side they had training and supervision.

Mrs Gardner noted the CSE element and they spoke to secondary schools about FGM, however FGM could happen before the age of 11. She questioned what they were doing to get into primary schools to raise the FGM element. Shawinder Basra-Dhillon noted that they were part of that working group, they were doing a lot of promotion around that, however school was taking that on board. A lesson in Year 6 which the teachers deliver with the support of the school nurses. The roadshows at schools worked for encouraging discussions.

Mr Lewis noted that they had the fifth largest number of patients who were survivors of FGM. He questioned if that data indicated anything about the effectiveness of their services. Shawinder Basra-Dhillon noted that it was about having those conversations and the work they were doing in FGM, developing a new policy and working in partnership with Public Health and school nursing. Mr Lewis clarified that he meant were those people from elsewhere or had they been through the program. He stated that the data should be data mined to identify if they were missing a group of people.

Mr Laverty noted child obesity and exercise and queried if there was anything they could do to link in with the Commonwealth Games. He noted that there was a requirement for the Games to leave a legacy, so there could be funds and programmes that could be tapped into there.

13.3 Paediatric Allergy Service	**TB (07/19) 018**

Faye Mathias noted that it was great to be part of a forward-thinking allergy team and that staff morale in regard to nursing had improved in the last few months. Their focus over the next 12 months was:

- Improving transition care – developing focus groups (children with allergies and parents with allergies).
- Aim to develop the online development tool for adolescents with allergies as a national tool.
- Complete non-medical prescribing – which would allow for more nurse clinics.
- Work with Allergy UK to develop online tools to use on the Trust website.
- Work closely with a pharma to produce an information sheet for anaphylaxis management in 25 different languages.
- Continue to celebrate their successes at local, national and international seminars.
- Work with the National Institute of Health Research to further develop Rhinolight Therapy research.
- Continue to support and promote the education for GPs, allied health care professionals and teachers.

Ms McLannahan note the demand patterns for the service and local waitlist and questioned if there was

growth potential for a regional centre. Faye Mathias noted that there was huge potential for further development – people came from all over the country to use their service.

Mr Lewis noted that as they develop as a tertiary centre, they may award GPs practice with funds to develop as an allergy expert practise. He questioned what indicators of GP expertise would they be looking for in awarding those GPs the funds. Dr Makwana noted that there were some innovative GP practises in London that had taken over allergy and then as the money stopped and GPs retired it phased out. It had positive outcome; patient satisfaction, less hospital admissions, care was improved. The indicators could be:

- Less hospital admissions.
- Anaphylaxis – good quality of life measures.
- Reduce all unnecessary referrals.

13.4 Paediatric Diabetes Service	**TB (07/19) 019**

Lisbeth Hudson noted:

- They look after young people from 0-19 years of age.
- Mainly have Type 1 Diabetes (autoimmune condition).
- Increase of Type 2 Diabetes (highest in the country, nationally 2% and localised (City) 17%).
- Embracing technology:
    - Patients can download the blood glucose metres and pumps for remote review.
    - Medical staff can phone back changes required in their routine.
- Offer structured education – by the age of 19 that they were self-managing in their transition to adult services.
- Reduce the sense of isolation through structured education, social events (funded by charitable events), support.
- Paediatric Research Nurse works with the team.
- Obesity strategy:
    - National Framework Committee meets quarterly and they invite the Obesity Public Health and Primary Health representative to that.
- Development areas in the next 12 months:
    - Continue to work with Primary Care to reduce rates of newly diagnosed children admitted in DKA – a preventable condition. To place alerts and guidance during the electronic referral process.
    - Recruited 2 nurses – focus on training to become nurse specialists.
    - Paediatric Department would benefit a family support worker.
    - Facebook page – in progress
    - More structure in the telephone clinic
- An increase in under 5's diagnosed with Type 1 Diabetes
- Schools were offering pizza, sausage rolls for a mid-morning meal. Education needed around the school strategy.

Cllr Zaffar noted that there was a greater risk of Type 2 diabetes in certain communities and questioned if they were doing any proactive work in those communities. Lisbeth Hudson noted that people usually came to them as either pre-diabetic or diabetic, but there was more to be done in that area.

13.5 Children's Complex Care Team	**TB (07/19) 020**

Harminder Bray noted the plan for the next 12 months for the complex care team:

- Staff would like to increase the case load which meant increasing their clinic skill set – professional development.
- Move the time taken from authorisation of a package to delivery of the package from 6-8 months to 3 months.
- Long-term ventilation to patients in the community. Would like to be the choice provider for Sandwell and West Birmingham.
- Development of an out of hours service – clinical advice for child and family and support for staff, extended to end of life care.
- Look at non-medical prescribing and improve their clinical assessment skills of the nursing team.
- Look at support packages for autism.

Mr Lewis suggested that the Board should support a two year investment programme. Colleagues accepted that idea in principle.

Mr Lewis to work with WCH Group to agree a basis for long term investment	
13.6 Children's Services: Our Quality Plan Targets	**TB (07/19) 021**

Dr Makwana noted that:

- The focus was objective 8 – reducing lost days at school. From an acute illness:
  - how to get the child out of hospital quickly,
  - managed at home, and
  - back to school.

  Looking at the reason for those three potential blockers, and getting the child back to school.
- Transition to adult services – difficult time due to hormone changes coupled with an acute condition – knock on effect to mental health etc. Good transition processes were in place and working with others to improve the process.
- Special needs had a multi-disciplinary team – not one single body looked after them. They become a condition, rather than a person – would like to change that.

It was noted that there was no adult provider in Sandwell for those transitioning adolescents requiring complex care.

Ms Barlow noted that they had a university population and therefore had a lot of people coming from other places and queried how they would manage that. Dr Makwana noted that they traditionally had lost those children in transition and they would look at where those gaps were and the opportunities to fill them.

Mr Lewis stated that they would need to decide how serious they were about preventing children taking time off school and if it was a solvable problem. Dr Makwana noted that it was solvable by moving appointment times outside of school hours and thinking outside the box. Mr Lewis noted that that contradicted what they were told last Monday – they were very rigid about the time structures.

The Chairman thanked the Children's Services team for their presentations.

MATTERS FOR INFORMATION/NOTING	
14. Finance Report: Month 2 Results and Q1 Forecast	**TB (07/19) 022**

Ms McLannahan provided the Board with a summary of the Paper:

- Contained a forward and backward look at what they anticipate Q1 to look like.
- On plan for month 2 overall and expect that to be the case at Q1 and month 3 – they would be able to claim Q1 of their support funding.
- Within that position they were significantly under their income plan and underspent on the Pay Plan.
- Income perspective – mainly a day case on the Production Plan
- Pay perspective – mainly driven by vacancies and high agency spend of £1.5m/month
- Q1 trend set to continue.

Ms Barlow noted that in terms of the Production Plan, at the end of Q1 they anticipated that they would be £900,000 down on their internally faced plan. The underperformance was not distributed across all specialities, most specialities were over-delivering, including ophthalmology. If they repeated the May activity each month, they would deliver to plan on Q2. There was tension and concern with the orthopaedic team that seemed volatile – Ms Barlow and Mr Lewis were to meet with the theatre and orthopaedic teams in regard to competence and consistency of the theatre teams.

Ms McLannahan noted:

- Capital expenditure was slightly behind plan in month 2.
- National constraint on the amount of capital expenditure available nationally compared to what all trusts had indicated that they would spend on their plan. Looking at reviewing that across the STP – a large proportion of their capital was committed to Midland Met Hospital.
- A lot of work done on cleaning up the aged debt.

Action: Ms McLannahan to provide a breakdown of the £900,000 of the underperformance in the internally faced plan (Production Plan) into speciality areas.

15. NHS Regulatory Undertakings – Monthly Status Update	**TB (07/19) 023**

Mr Lewis noted the Paper and stated that it was a legacy of the undertakings process. Everything in the Paper had been discussed elsewhere at the Board. The Quality and Safety Committee would devote time to scrutiny of the NHS Constitution Emergency Care Standard for consideration at a subsequent Board meeting.

16. Annual Medical Revalidation Report	**TB (07/19) 024**

Dr Carruthers noted that the report would be presented at the next People and OD Committee meeting. The paper included:

- Summary of medical staff appraisals.
- Reflected on different grades of doctors that are involved in the Trust, not including trainees.
- The number of recommendations for revalidation.
- Breakdown of staff where appraisals were not undertaken, the reasons why and increase the doctor's understanding of the importance of the appraisal process (induction video to highlight the importance of appraisals).

Take revalidation reports for medical and nursing staff through POD committee	**RG**

17. 7-Day Service Standards and Board Assurance Return	**TB (07/19) 025**

Ms Barlow noted the Paper and confirmed it had been agreed by the Board's quality and safety committee.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS

18. Minutes of the Previous Meeting, Action Log and Attendance Register	**TB (07/19) 026** **TB (07/19) 027**

The minutes of the meeting held on 6 June 2019 were approved as a true and accurate record.

Action Log Update:

- *TB (11/18) 015 - To circulate additional reconfiguration working papers to Trust Board members.*

  Mr Lewis reminded the Board that the reconfiguration was to do largely with respiratory medicine but also the associated piece on Paediatrics – they continue to progress and were nearly there. There was a program for the respiratory part and if it wasn't done by August – it would not be done.

- *TB (01/19) 012- The commitment on the validation on open referrals is to be completed by the 31 March*

  Mr Lewis noted that they were slightly behind with 15, but would get there over the next few weeks.

- *TB (05/19) 015 - Contact Prof Melanie Calvert, University of Birmingham, to invite her to assist with the work on definition and metrics of coordination*

  Ms Wilkin noted that she was in the process of setting a meeting date and would update next board meeting.

19. Any Other Business	**Verbal**

<u>Never Event</u>

Dr Makwana presented immediate feedback on a Never Event as follows:

- Gynaecology – 66-year-old lady with uterine cancer needing a total laparoscopic hysterectomy (removal of uterus and lymph nodes in abdomen to see if any spread of cancer and biopsy of fat of stomach to see if it had spread).
- Surgery performed with no issue, wound closed. The swab count was taken and documented as correct.
- Next day patient reported discomfort. Nurse performed a check and a vaginal swab was left in situ. It was removed immediately and doctor spoke to patient and provided an explanation.
- Patient went home the next day and came to no harm from the event.
- Patient due to be reviewed again this week and receive the results of biopsies. Confirmed that swab bowls were used.
- Theatre procedures were being followed and safety checks were being carried out and anticipated that this would not reoccur.
- The incident decision tree was being used in the investigation process.

Mr Lewis clarified that when swabs go into the patient and then count them out again, that it was not possible to introduce more swabs. It was confirmed that was the process and they would investigate further.

Mr Kang queried how he was reassuring himself that the staff were telling the truth. It was noted that the staff were able to recall that they knew the process and trusted that. Mr Roy clarified the process of counting swabs in theatre for the Board.
20. Details of Next Meeting
The Public Trust Board meeting would be held on Thursday, 1 August 2019, 09:30-13:15 in the Conference Room, Education Centre at Sandwell General Hospital.

Signed …….

Print …….

Date …….