Sandwell and West Birmingham Hospitals NHS
NHS Trust

TRUST BOARD – PUBLIC SESSION MEETING MINUTES

Venue: Conference Room, Education Centre, Sandwell General Hospital

Date: Thursday 1st August 2019, 09:30 – 13:15

Members:

Mr R Samuda	(RS)	Chairman
Mr H Kang	(HK)	Non-Executive Director
Mr T Lewis	(TL)	Chief Executive
Dr D Carruthers	(DC)	Medical Director
Mrs P Gardner	(PG)	Chief Nurse
Mrs R Goodby	(RG)	Director of People & OD
Ms R Barlow	(RB)	Chief Operating Officer
Prof. K Thomas	(KT)	Non-Executive Director
Cllr W Zaffar	(WZ)	Non-Executive Director
Ms L Owens	(LO)	Finance Advisor
Ms M Perry	(MP)	Non-Executive Director
Mr M Hoare	(MH)	Non-Executive Director
Ms A Binns	(AB)	Deputy Director of Governance

In Attendance:

Mrs C Rickards	(CR)	Trust Convenor
Mr D Baker	(DB)	Director of Partnerships and Innovation
Ms B Hughes	(BH)	Director of Operations
Ms T Davies	(TD)	Group Director of PC,C&T
Mr K Sharobeem	(KS)	Director of Admitted Care A
Mr C Simpson	(CS)	General Manager, Admitted Care B
Dr S Sivasubramaniam	(SS)	Clinical Director for Theatres

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 Mr M Laverty, Ms D McLannahan, Miss K Dhami and Mrs R Wilkin.	
3. Declarations of Interest	**Verbal**
No declarations of interest were noted.	
4. Patient Story	**Presentation**
Mrs Gardner introduced Jasim, the patient, and his mother Naz and invited Jasim to present his patient story. Jasim noted that he was 16 years old and had just completed his GCSE. He presented his patient story to the Board with the following key points: • The allergy commenced when he was four months old. He was given a creamy porridge and broke out in hives, rashes and his breathing stopped. He was rushed to hospital where he was diagnosed with a severe allergy to dairy. • Primary school was a difficult time as he wasn't able to participate in normal childhood activities, such as; pass the parcel (where the prize was often chocolate or sweets), had the same packed lunch everyday whereas other children had hot school meals – he had felt left out. • Secondary school was also difficult as he had to re-explain the allergy to new people and explain	

the application of the EpiPen. Tried hot school meals, but selection limited – returned to a packed lunch.

- Impacted on family experiences such as, missed outings to dessert shops and frequented the same restaurants. He didn't enjoy or look forward to eating.
- Treatment:
  - Dr Makwana had informed his mother about a dairy allergy treatment.
  - The first step of the treatment was milk diluted with water – it went well and he gained confidence.
  - He couldn't wait to taste milk and had 200ml of milk in the last month – he had a small reaction (hoarse throat, rash) and took a step back as it scared him. After that experience he was fine – it was thought a cold may have contributed to the reaction.
  - The treatment had changed his life and expressed interest in becoming a paediatrician like Dr Makwana – he had inspired him to help other children like himself.

Prof Thomas questioned if the allergy had made it difficult for him to join in at school. Jasim confirmed that it did as he was unable to partake in any celebration because of the food. Prof Thomas queried if other children treated him unkindly. Jasim noted that they treated him properly, however he recalled a time when another child put a cheese and onion crisp to his cheeks which he had a reaction to. The teachers dealt with the situation and it never happened again.

Prof Thomas queried what it was about Dr Makwana that had inspired him. Jasim noted that Dr Makwana is smart, well respected and helped a lot of children. Jasim noted that he knows what it feels like, and wanted those children to feel how he felt after the treatment.

Dr Carruthers queried if Jasim had to miss any school because of the illness, if the hospital was flexible with their appointments, and if the hospital provided the school with enough information. Jasim advised that the school was provided with enough information and he had missed about two or three lessons to attend the hospital for an allergy check-up – he had done some home learning to catch up.

Cllr Zaffar queried if Jasim had come across others with allergies as he was growing up, and would it have been helpful to have a support group of children with similar allergies/experiences to him. Jasim noted that it would have been helpful as his confidence was low – his parents had enrolled him into boxing class to gain confidence.

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

Bill Hodgetts noted the Urgent Care Centre which would open when the A&E closed, and questioned the operating hours and if it would be walk-in care or ambulance only.

Mr Lewis advised that when the A&E transfers to Midland Met Hospital, that they would open an Urgent Care Centre in the same space where the current A&E was located. They expected that the Urgent Care Centre would:

- look after 38,000 patients – a big operation.
- Operate 7 days a week, 24 hours a day.
- Consideration for young children to be diverted to Midland Met Hospital after 10pm
- Mr Lewis noted that they would probably replace the walk-in centre that was located with the GP practice, Lyndon Health. A public information campaign would be developed next year.
- They were exploring the extent to which the use of video technology in the Urgent Care Centre could provide access to specialists and clinicians who were based at Midland Met Hospital. The Urgent Care Centre staff would consist of emergency nurse practitioners – some of which they had

and others to recruit to, some GPs and some other groups of staff that would rotate through Midland Met Hospital and the Urgent Care Centre in order to retain skills for more complex patients, as well as straight forward care. The more that local GPs developed their own urgent care facilities, maybe the smaller load/demand on the Urgent Care Centre. The Urgent Care Centre was there for the long-term.

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

The Chairman noted that he had attended the Stepping Up event held for all of the Black Country Trusts, for developing minority ethic staff in to management roles. He stated that he was proud of the Trust and the efforts in which they had made – the Trust had fantastic feedback from other trusts on the staff that were leading it. It was clear that the Trust was leading the efforts in the area. The enthusiasm, commitment and value of support was energising.

Mrs Goodby advised that they had set and achieved a target percentage for BME representation in senior roles within the organisation. Mr Lewis questioned if the Trust was attracting people from non-clinical professional roles into the Stepping Up program. Mrs Goodby advised that there was a diverse range:

- BME staff above an 8A (exclusive of doctors) had increased, 19.7% to 23% (target 25%).
- The Stepping Up program had two cohorts; Band 5/6 and Band 7.
- There was a wide range of non-clinical staff involved (nurses and matrons, junior HR, finance and administration).

Cllr Zaffar noted that the Trust had recognised the issue and implemented action whilst leading other Trusts along the way. He also commended Mrs Goodby for her leadership in the area.

The Chairman noted that he and Mr Lewis had attended a meeting of the STP Chairs. He advised that there were two new chairs on the patch. There was common ground that the five places that they had identified (including West Birmingham) were the key building blocks. They had discussed what could be done at the centre to engage providers in progressing and influencing the commissions.

Mr Lewis noted the need for a community-based services collaboration to overcome the challenge of people residing in one geography and receiving their health care in another. On the assumption that that would not change, an equitable solution to that would need to be agreed. He noted that it would be worthwhile that over time, they identify those touch points.

UPDATES FROM THE BOARD COMMITTEES

7a	**TB (08/19) 001**
Audit and Risk Management Committee	**TB (08/19) 002**

a) Ms Perry provided the Board with an update from the Audit and Risk Management Committee meeting held on 4th July 2019, with the following key points discussed:
   - Focal point for the coming months would be the Financial Systems Improvement Plan, due to some concern about audit points from the Grant Thornton.
   - Internal Audit Plan – would cover areas such as; people governance (appraisal and recruitment processes), quality and safety governance and IT governance and cyber security.
   - Positive progression in overseas visitors' charging with systems and processes in place to identify overseas visitors and ensuring that they are charged and payment received.
   - The Speak-up Scorecard would be reviewed in detail to identify the actions and plans for hot spot areas.

b) The minutes of the Audit and Risk Management Committee meeting held on 23rd May 2019 were received by the Board.

7b Finance and Investment Committee	TB (08/19) 003 TB (08/19) 004

a) Mr Hoare provided the Board with an update from the Finance and Investment Committee meeting held on 26th July 2019. He noted the following committee discussions:

- Procurement Plan, the activities associated to the improvement of the procurement function and the cost-savings associated with that – significant work completed on the supplier database and contracts associated to those, and improvements to the standard catalogue. There remained significant challenges ahead, however actions and activities were in place to address those.
- Financial Recovery Plan – remove the underlying deficit and associated challenges with the CIP, income improvement and the associated operational improvements.
- The associated opportunities around GIRFT, Model Hospital and the Right Care savings – would investigate how those opportunities would be addressed within the budget setting of 20/22.

Mr Lewis noted that his expectation was to set highly differentiated targets based on scale of opportunity, rather than applying savings targets on a pro-rata basis. It was a controversial and difficult thing to do – all the appropriate people would need to be in the room to make those decisions.

b) The minutes of the Finance and Investment Committee meeting held on 24th May 2019 were received by the Board.

7c Quality and Safety Committee	TB (08/19) 005 TB (08/19) 006

a) Mr Kang provided the Board with an update from the Quality and Safety Committee meeting held on 26th July 2019. He noted the following discussion points:

- External maternal learning enquiry – the enquiry was underway with the final report due end of August. The themes of learnings in which could be adopted had been discussed.
- 4-hour emergency care standard – to be discussed at agenda item 12.
- SBAF – it was agreed that effectively, the ratings provided were intact.
- IQPR Thresholds – now had a feel for the targets and the trajectory.
- Never Event – to be reported at agenda item 16.

Mr Lewis noted that over the next two or three months, the Executive would need to bring back their views of quality in the three General Practices, and that would need to feature in the Quality and Safety Committee.

b) The minutes from the Quality and Safety Committee meeting held on 26th June 2019 were received by the Board.

Action: Executive to consider their views on quality in the three General Practices to be featured at the Quality and Safety Committee.

7d Digital Major Projects Authority	TB (08/19) 007 TB (08/19) 008

a) Ms Perry provided the Board with an update from the Digital Major Projects Authority meeting held 26th July 2019, and noted the following meeting discussions:

- Reviewed the articulation and scoring of the IT-related risks on the Risk Register.
- Audit and penetration testing had been completed – reports pending issue.

Mr Lewis noted that the DMPA had circulated reports of an air conditioner outage, a telephone-related outage and subsequent telephone issues. Those issues highlight the importance of ensuring that the

governance of decision making and the structure of the IT function was where they want it to be. Work would be done over the coming weeks to map corporate functions that were crucially dependant on interactions with IT to gain an understanding of the landscape.

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

7e	**TB (08/19) 009**
Public Health, Community Development and Equality Committee	**TB (08/19) 010**

a) Professor Thomas provided the Board with an update from the Public Health, Community Development and Equality Committee meeting held on 26th July. The following key points were noted:

- Smoke-free update:
  - Positive progress with very good engagement.
  - Requests for the Trust's implementation kit – the Trust would launch a No-Smoking Collaborative in which they would charge for their engagement.
  - Mr Lewis noted that it appeared that the quit activity related to vaping and they would work with their supplier to progressively encourage those people to reduce the use of vaping. The wider reaction to vaping had broadly been positive. The Birmingham City Council were looking at using vaping as part of their quit offer.
- WRES, DES and pay gap action plans.
- Discussed the 14 objectives and had accepted the analysis that; they were performing well on five, had a plan for six, and had not yet addressed three. Obesity would be the next focus item.

b) The minutes from the Public Health, Community Development and Equality Committee 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, including Board specific SBAF	**TB (08/19) 011**

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

- Smoke-free – the cooler seasons would present new challenges in the management of the sites. There were two or three residual hot spots where additional focus was needed. They would continue to problem solve and reenergise as they proceed.
- Work continued on safe staffing in nursing and health care assistant numbers. It had been identified that 15% of shifts tended to have less people than considered necessary – continue to work through that gap. A daily audit tool commenced on 31 July for shift leaders to identify those risks, and had they been mitigated.
- The Report was missing annexes in which would be issued with commentary:
  - Vacancy position, in particularly vacancy forward look. Most jobs were out to advert and at least 700 were out to some form of offer.
  - Imaging wait time improvement projects – one supplier had come on line and were looking to see those numbers improve through September.
- The manager's Code of Conduct would be launched on 9th August.
- The SBAF Report on the three risks that report directly into the Board; GP recruitment, commissioning landscape changes, and conclusion of the work on response plans, ICPs and alliances. For different reasons they were not at full assurance on each item as detailed in the

Report.

- Midland Met Hospital – the remaining cranes would be removed at the end of August and were coming to the end of the early works process. They would need to move forward with an agreeable proposal with government officials by 31 October. If that date was not achieved, the target price and the Commonwealth Games timescale would also not be achieved.

The Chairman queried the pension debate and asked for it to be put into context. Mr Lewis noted that it related to changes in which people pay tax on their earnings and liabilities associated with their pension pots. The Trust had introduced an interim scheme from 1 August for medical staff (including GPs) to pay 12% of what would have been the employer's contribution to people who come out of the scheme. There was an indication that the Government expect to announce policy next Spring. He advised that 52 people had come out of the pension scheme in the last 18 months.

The Chairman noted the letter in which was sent around nationally as to what extent Trusts were able to carve out time for those trying to help in the Guardian area. He invited Mr Lewis to respond to that letter in regard to their efforts in sufficiently protecting time. Mr Lewis noted that they were working with the Guardian's as to their role in a suite of different things that they need, including trade union colleagues to support staff, and to what level of time protection might be useful. He advised that Ms Perry's report details how the Board was assured in the freedom to speak up in the organisation and to the speak up Guardians – to treat those as two related but distinct different issues.

The Chairman requested that the measures of dementia identification amongst primary care partners be put into context. Mr Lewis noted that it was about how performance management in the NHS might change. They need to make sure that the way that was deployed was purpose served and functional – not failing because they did not have a system plan. The issue was the need to identify their 'population' to understand their world – two populations (Sandwell and West Birmingham). That would need to be worked out with the CCG at the meeting on 2 September 2019.

9. Integrated Quality and Performance Report – May	**TB (08/19) 012**

Dave Baker noted that the Report had been reviewed by the Performance Management Committee, the Quality and Safety Committee and CLE. He noted the following:

- Good progress in the areas of; open referrals, imaging (time to scan) and bed moves after 10pm (dropped by over 100).
- Two indicators had returned to persistent reds; late cancellations and reattendance rates – shows that as they focus on areas, they improve; sustainability was an issue.
- New indicators in the IQPR; Imaging, exception page now includes ward sickness (with big variances in numbers by wards).

The Chairman questioned the average ward sickness of 6.7 in June. It was noted that on 18 June the Clinical Groups had in depth discussions around ward by ward plans of hot spot areas and how to reduce those numbers with a timeframe. There was a concerted effort in the wards to support the intensive work that Mrs Gardner was leading with rostering to get to an acceptable level of sickness. Mrs Gardner noted that there were a number of impacts on sickness; size of ward/staff levels, ward leadership disciplinary actions. It had been suggested to put the sickness stats in the wards to present to staff how sickness impacts on the team and to learn from wards with low sickness rates. Human Resources had also implemented administration support for line managers to manage short term sickness.

Cllr Zaffar noted that they had looked at the issue consistently and questioned the measures in which they were assessing against, and if there was a ward that was known to be an issue ward, should they dedicate senior leadership's time to investigate/support further. Mrs Gardner noted that the stats did change monthly, and they had not in the past selected a ward but could certainly do that. Mr Lewis noted that the long-term sickness drove ward sickness to some degree. He was keen to look at sickness and vacancy

through the prism of the red shifts. If they could rectify vacancy, that would lead them into sickness as the remaining residual issue to investigate roster patterns (night shifts, weekend shifts or long-shifts give rise to patterns of sickness).

The Chairman noted that the indicators on A&E readmissions were increasing. Ms Barlow noted that the nursing home work and other community initiatives were starting to show early results of improvement in readmissions. They would recut that data by a different population to find a refocus through the Quality and Safety Committee.

Mr Lewis noted that it would be helpful for the Board to be clear on which indicators had a signed plan in place and log the local plans that had been rejected.

The Chairman noted the serious incidence increase and queried if there was commentary on the trend or any system stress. Ms Binns advised that the reporting mechanism had changed and therefore the data was not comparable.

Action: Log which IQPR indicators had a signed plan in place and any local plans that had been rejected.

10. Risk Register Report	**TB (08/19) 013**

Ms Binns advised that the CLE had updated the Risk Register in June. They looked at whether the risks were actually 'issues' and should not be on the Risk Register, or did they need to further articulate the risk and the scoring mechanism with mitigations to reduce that:

- 58 of the 309 risks originally identified, had been archived as they were identified as issues – to be managed and monitored by the Groups.
- Spot check on those risks identified as needing scoring or risk articulation revision.
- They were challenged to manage incidents in a timely manner – large amount of work in progress.

Mr Lewis noted that the CLE exercise had identified a failure of risk management – in the vast majority of cases it was evident that people had not scrutinised the risks. Everyone had committed that by 12 August it would be updated. A tool was being explored to assist local directorate managers to track and maintain an issues log. By the Q4 Board he expected that they would be reviewing whether risks were moving through the system or not (that was the measure of risk activity) – not reviewing the number of risks and their ratings.

Mr Lewis noted that they had agreed that the risk register should be split in two; updated risks that had had action, and risks with no action taken, and expected that to be completed by September.

Action: Split the Risk Register in two; updated risks that had had action, and risks with no action taken – to be completed by September.

BREAK

11. Unity go-live readiness	**TB (08/19) 014**

Mr Lewis stated that at the September Board meeting, he would request that the Board make a Go or Stop decision – with a go decision, further decisions to be delegated through September. He noted that the Paper was a run through of that and to remind the Board of various approved criteria:

1. Trust Level:
    - policy and compliance criteria drawn from analysis of West Sussex, Worrall and NHS Digital, and allied to that some Cerna criteria (trial load/data flow etc).
    - People readiness mobilisation – Board recognition of gold, silver and other departments, individual competency, departmental competency and the individual/team competency in

simulation. Capman training had gone live that morning and would have routine data throughout August on its progress.

2. Directorate/Departmental Level:
    - Readiness heavily impacted by Wi-Fi, BMDI, BCPs digital champions and super user training. More effort in August to be placed in education around the difference between digital champions and super users.
    - Wi-Fi accessibility to be completed in mid-August.
    - Device roll out delayed until end of August which adds to the risk profile of the September go live decision.
3. Individual/team competency:
    - Individual evaluation of competency versus their manager's opinion on their competency.
    - A couple of weeks behind on team readiness.
    - The launch of the team simulation was preconfigured in July, and would independently out of project audit that at the end of August/beginning September.
    - Team simulation needs to be practiced with devices in situ.

Mr Lewis noted they are behind in their expected progress; however, it was still recoverable. Preparations continued to be made on the basis of go live and would continue to do so until the September Board where a decision would be made.

Mr Kang questioned the effect on capacity if things did not go to plan and the mitigation plan in place for that. Mr Lewis advised that in planned care and diagnostic areas that the volume of patient work would be downscaled for up to two weeks by up to 40%. For patients attending regardless; gold teams to staff at 120% staffing base, and silver teams to staff at 110% of staffing base. The risk would be that it impacts at more than 40% or that they did not pull up over two weeks and it lingers.

Mr Kang questioned the health economy system and if the Trust was expecting help or understanding from the community. Mr Lewis advised that the go live of a new EPR had been publicised with peer organisations and would renew that message in September. There was a live conversation with WMAS about ambulance flow.

The Chairman queried the interface to have the kit on the Wards in the run up to go live. Mr Lewis advised that the kit was the same that staff already had – there would be simply more of it. Considerations to note:

- Device connection setup – done right on the first attempt.
- Differences in Wi-Fi coverage sites.
- Some care pathways in the Trust were device connection was critical.
- Device kit storage.
- Working with devices around patients and accessibility to patient – some in-practice testing completed.

The Chairman queried considerations to more kits and infectious disease control. Mrs Gardner advise that infectious control, cleaning and ergonomics of the kit had been tested and the Infectious Control Team were involved in that. Mr Lewis advised that the Infectious Control Team would attend the September Board meeting to present on infection control in the wider organisation. Local nurses would be charged with maintaining cleanliness of all kits clean – how that would be tracked was to be resolved.

Mr Lewis noted that the Clinical Safety Case was being prepared and would be published in late August.

12. 4-hour emergency care standard: Realising the benefits	**TB (08/19) 015**

Ms Barlow noted that the Paper was the first of a series of papers structured around emergency and acute care in item 13. The key points around ED performance improvement:

- Admissions remain above plan in circa of 10% – further analysis required to understanding reasons.
- Goal was to reduce 4-hour breaches by 30, in the past two weeks demonstrated a reduction of 13.
- PDSA cycle affective in minors with some performance improvement in BMEC 2.
- 4-5-hour breaches had made some impact on those – the team had been stimulated and reenergised by; the NSHI visit, team visit to Leicester (review of innovation in practise), and another PDSA cycle where a senior doctor would be placed into ambulance assessment (expected to reduce diagnostics).
- Good progress on recruitment; focus on onboarding and staff retention.
- 5-7% Sickness and attendance challenge.
- Risks:
    - Strategic cell had experienced significant batching – found that challenging and overwhelming and were working with commissioners and regulators on how they could work in collaboration to make that a safer system.
    - Understanding of system bed plan longer term and nursing home market.

Prof Thomas noted a radio story about Brighton and Sussex where they had implemented a new junior doctor rota system which had had a dramatic impact on the retention rate in ED. Dr Carruthers advised that they had advanced investigations in to that software for possible implementation in the acute areas.

Mr Kang queried if it was timely to commence community messaging around what an A&E department was for. Mr Lewis noted that they had implemented single point of access that was working well to deflect people who need care, but not necessarily through the A&E. Interventions were based on patient statements on the reasons they come to A&E; imaging waits (unable to get from GP), and GP availability (need to consider if attendance rates differ by practice were in anyway corelated to availability of appointments). The Trust had said that they would fund a project that looks to relocate people back from A&E to their local GP practice over the course of the next year – that may make a difference.

Mr Lewis noted that the volume of ambulances was also an issue. Currently there was not an A&E system that delivered on targets. Time frames of patient visits need to be clear – weakest spot at the moment was a standard form to deliver. Their standard form was to deliver in 5 hours and a way to expediate that process needs to be identified. They either need to get more cubicles and accept that patients stay for four hours, or they find a way to push patients through in two hours.

The Chairman queried what feedback was received from the external reviewers on that point. Ms Barlow noted that the key points had been summarised on the front page of the Paper:

- Emphasise on opportunities to stream patients away from the A&E to GPs – the Trust had some of the best streaming stats in the region which meet national expectations.
- The number of children that are streamed to A&E.
- Recommendations around out of hours ambulatory care units.
- There was not a significant recommendation on how to reduce attendance rates.

Mr Lewis stated that the Trust had asked for additional clinical help to coach clinicians around making risk-based decisions at initial triage and initial assessment as they were more risk averse and cautious than best practices suggests. The first two hours was crucial. The number of cubicles was important and the behavioural trends of clinicians. It was about how the A&E team as a whole functioned.

Beth Hughes noted that there were a group of people who worked hard to improve things and they had been working hard to expand that group of people for sustainability. It was important for staff to understanding KPIs in the department and the need for improvement. Leadership on the floor was key to

success.

13. Organising acute beds to 2023	**TB (08/19) 016**

The Paper was noted and elaborated on further in the following sub-papers.

13.1 Population health: One coordinated care pathway	**TB (08/19) 017**

Ms Davies noted that the Paper was an analysis of their accessibility in community care and was in two parts:

1. Evaluation of their community case load in comparison to their local population (identifying any gaps).
2. Acute to community pathways (did they work efficiently and were they accessible).

The data quality in the Paper was an issue, for example, ethnicity was not recorded for 24% of patients in their community case load. There was a need to do something about that, but it should not detract from the information within the Paper – there were definite indicative trends that need further investigation.

Evaluation of community case load/population:

- The community case load mirrored the local population particularly in the four most prevalent ethnic groups. However, at an individual team level, that wasn't the case – there was a much higher percentage of white British patients in that case load.
- Some groups were missing in their case load, such as new and emerging communities.
- An analysis of the diversity of staff revealed that they were a diverse workforce, however at higher grades/bandings it dwindled out – typical of national trends and were working to bridge that gap.

Bridging community pathways:

- Offer high quality and diverse community services. The issue was that they are not always taken up by the right patients.
- Currently undertaking a 48-hour project – contacting patients within 48 hours of discharge to find out if they had a community services need. Leads to questions whether the pathways were right and accessible to their acute colleagues.

Objectives to bridge the gap:

- Take the respiratory pathway as a test pathway; an in-reach model, utilisation OPAT services etc.

Mr Kang queried if there was a link between the type of workforce and the type of patients in which that attracts. Ms Davies stated that it would be an assumption, but thought there was a link – in communities there are certain expectations in treatment and the Trust needs to understand those expectations. There was a link between robust community relationships and patients from those communities, those less robust relationships showed gaps.

Mr Lewis noted that it would be helpful to look at for a nominated period of time, how many attendances could have had a contact with community services. Ms Davies noted that there was merit in doing that, to look at the patient notes in detail and identify any gaps – that would align well with admission avoidance. Mr Lewis suggested that she collaborate with Matthew Maguire who had completed data analysis that would provide an interesting view.

Ms Perry questioned if patients were directed to the Trust's community services. Ms Davies noted that the consistency of that direction was personnel based. There was lack of knowledge and understanding of services provided and how to access those services, therefore they want to have a one contact point for all

services.

Ms Barlow suggested that it would be beneficial to run the same analysis on paediatrics.

Action: Prepare a paediatrics equivalent analysis of the demonstrated analysis in paper *TB (08/19) 017 Population health: One coordinated care pathway*.

13.2 Mobilising diagnostic support: One set of promises	**TB (08/19) 018**

Ms Barlow noted that the Paper was an extension on papers previously presented to the Board to improve time to test for patients. There were three clinical standards recommended:

- 4-hour turnaround for rapid cardiology tests and chest drain insertions.
- 24-hour turnaround from request for all inpatient tests and speciality opinions.
- 48-hour turnaround from request for PEG and colonoscopy (to allow form clinical preparation time).

Consistency in the delivery of the clinical standards was not evident and would look to introduce a robust system for tracking their time, from request – to test – to report. Unity would provide the ability to do that. The risk was they need to balance planned and emergency care.

She noted that specialities that did not have 7-day specialist rotas need to focus on those being 5-6-day services that respond well.

Mr Lewis stated that he would prefer the 24-hour turnaround be 36 hours. 24-hours was not achievable in a real-world scenario – they really want a next day delivery at 100%, not 80% success for 24-hours giving. Mr Lewis questioned the Q4 19/20 timeline detailed in the Paper. Mr Simpson confirmed that Q4 19/20 was selected due to the expansion of the endoscopy unit.

13.3 Bed numbers and configuration 2019-2023	**TB (08/19) 019**

Mr Lewis noted that the Paper reflected a set of improvements in potential bed numbers based on further improvements in length of stay. If that failed or was delayed, they would struggle to manage bed base, especially at Sandwell. It was the intention to relocate respiratory care and inpatient care before the end of 2019 to City. He noted that it was important to not lose momentum on length of stay – currently at 99% occupancy, which drives ward sickness as discussed earlier. He noted that the Paper and the subsequent paper should be read in consideration of each other.

Ms Barlow noted that length of stay had reduced by one day last year – evidence that the team could achieve improvement. The current bed demand, outside of their funded and established bed base, was driven by the increase in admissions resulting in the need for 33 beds being used. If that continued, they would not be able to fit their admissions into the site over Winter.

She noted that as they host community services and had good engagement with the Council, the improvement opportunities were very much weighted on Sandwell. They hoped to emulate that engagement with the Birmingham Council to see improvement in Birmingham.

Ms Hughes advised that some of the initiatives had been recently implemented and were showing early signs of improvement.

The Chairman questioned if the Trust was improving the identification of end of life pathways. Ms Davies noted that one work stream was to reduce the fast track pathway at the end of life patients in acute beds who wanted to go to elsewhere to die. There were two elements to that; recognition of the dying patient, and delays in getting care for them. Money from the Better Care Fund would be used to increase their relationship with Cross Roads to provide them with health care assistance at the end of life pathway, and to support discharge of those patients during winter. Additionally, a seconded clinical nurse specialist would work with the complex discharge team and end of life care facilitators to improve the knowledge of

ward teams, medical nurses and therapists to recognise end of life patients.

Mr Lewis noted a project in the Quality Plan that investigated the resourcing levels for the palliative care team, in particular the respiratory and heart failure patients. Focus on what the admitted experience was meant to be and try to manage against that expectation.

Mr Kang noted that the accountability was placed on multiple individuals and suggested that it was worthwhile to identify one individual to take ownership.

Action: To identify one individual to take ultimate ownership of each item within the Bed Plan.

13.4 Completing the respiratory reconfiguration for winter 2019	**TB (08/19) 020**

As covered in the above discussions.

14. Speak up scorecard – draft	**TB (08/19) 021**

Ms Binns advised that the Speak Up scorecard would be monitored through the Audit and Risk Committee and covered off in the CEO's Report. She noted that the draft paper detailed how the strategy would be monitored, as previously agreed. Many strands were identified such as, the Guardians' role (as discussed earlier) and learning from excellence (WEConnect). It was noted that there were indicators arising from Speak Up. Turnover was suggested as another indicator.

Mr Lewis requested that they recognise what score constitutes a boundary of acceptable within each indicator to enable effective and well-informed analysis – easy identification of what was high/low. It was requested for the JCNC to also see the Speak Up Scorecard regularly.

Action: To establish scores that constitutes a boundary of acceptability within each Speak Up Scorecard indicator to enable effective and well-informed analysis.

15. PDR moderation – governance and audit for August	**TB (08/19) 022**

Mrs Goodby drew the Board's attention to the timelines detailed in the Paper:

- The hard stop for PDR moderation to start was 2 August – if not completed, a score of 1 would be given. She advised that was not a new concept and that some kick back was expected, which would be dealt with on an individual basis.
- PDR moderation throughout August
- Outcomes to be brought to the People and OD Committee in late September.

The following checks would occur:

- Line manager auditing of scores given.
- Identification of areas that had overall high/low scores.
- Consistency checks on mandatory training (unable to score above a 2 if mandatory training not completed).
- Inter-professional objective tests to ensure consistency in the size of objectives set for equivalent positions in the organisation.

Mr Hoare queried the appeals process once moderation had been completed. Mrs Goodby advised that the appeals process had changed slightly based on received feedback. Once moderation had finished and the action sheet completed, if a score had been reduced – a rationale must be provided face-to-face and via a standard letter. There would be also be an appeal panel.

Mr Lewis noted that they had agreed on a process of auditing the existence of, and coherence of

objectives in some areas, particularly for people with low scores. There needs to be evidence of those clear objectives being set. The message needs to be reiterated to managers that they objectives must be in writing and made clear to staff. He stated that there would be an audit on all scores, including the 'safe' scores of 2.

MATTERS FOR INFORMATION/NOTING

16. Never Event notification	**Verbal**

Dr Carruthers noted that Dr Sivasubramaniam would assist with the delivery of the verbal report. He noted that the retained object was in an ophthalmology theatre and was slightly different to the retained object issue reported last month.

The retained object was viewed by the Board to gain an understanding of how small the object was.

Dr Sivasubramaniam, Clinical Director for Theatres and Consultant Anaesthetist, introduced himself to the Board and provided a summary of the Never Event:

- Previous multiple eye surgeries for impaired vision, had an electo-plan procedure on 10 June in a BMEC theatre.
- Surgery was performed by senior training fellow under direct supervision of a consultant surgeon.
- The patient was reviewed one-week later at the follow up clinic and discharged.
- A month later she attended her family consultant and it was identified that there was a trocar in situ in the upper portion of the eye. The patient had a drooping eyelid, which meant it was not obvious. Patient had experienced discomfort during that month.
- Reviewed the next day at BMEC theatres and trocar removed under local anaesthetic.
- A TTR was conducted last week with a view to ask further questions:
    - were existing safety processes and procedures followed?
    - were there any system and contributing factors identified?
- Initial answers to investigative questions:
    - Underlying causes and contributing factors? Routine documentation completed and no cause for concern.
    - Was the patient care adequate and was there patient harm? The trocar caused discomfort and would have presented opportunity for infection, or could have resulted in the loss of the eye. The patient did not get an infection and vision was not affected.
    - Was candour of care provided? Verbally and in writing with reassurance that the event would be investigated and feedback provided.
    - Was the team supported? Team leaders and line managers believe that adequate steps and actions had been put in place to support the team members. Side review to be arranged.
    - Had other units had similar incidences and was the latest equipment used? The appropriate equipment was used. According to an NHSI publication, one similar incident in another hospital last year.
    - How can the risk be minimised or assurances that the issue won't happen again? The trocar was included in the checklist (always had been), reiterate the importance of the checklists, issue a learning alert to staff and reinforced at team meetings the importance of policies and procedures, checklist with good quality.

Mr Lewis requested that they take a detailed look at the conduct of the second visit (follow-up clinic) in the investigation.

Mr Kang noted that the trocar came in a pack of three, therefore one was removed and obviously the pack

remained with two trocars left in it – he suggested that that should have alerted questioning as to where the third was.

The Chairman noted that one common denominator in all recent cases was they were routine procedures that had some degree of complexity.

17. Finance Report: Month 3 results and Q2 forecast	**TB (08/19) 023**

Ms Owens advised that the Report was for noting and highlighted the following key messages:

- At the end of financial Q1, they were in balance with an underspend of £3m and £3m down on income.
- Strong balance sheet.
- Improvement on cash.
- Payments performance was improving.

18. NHS Regulatory Undertakings – monthly status update	**TB (08/19) 024**

Noted.

UPDATE ON ACTIONS ARISING FROM PREVIOUS MEETINGS

19. Minutes of the Previous Meeting, Action Log and Attendance Register	**TB (08/19) 025** **TB (08/19) 026**

The Board reviewed the minutes of the Public Trust Board meeting held on 4th July 2019.

The Chairman requested that the following sentence be made clearer on page 8 for prosperity purposes:

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.

20. Any Other Business	**Verbal**

No other business to note.

21. Details of Next Meeting

The Public Trust Board meeting would be held on Thursday, 5th September 2019, 09:30-13:15 in Meeting Room 2, Rowley Regis Hospital, Moor Lane, Rowley Regis B65 8DA.

Signed …….

Print …….

Date …….